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AIDS and Divorce

ANDREW SCHEPARD*

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I. Overview

AIDS is the greatest public health challenge of the late twentieth century. It is a frightening disease, inevitably fatal to its victims. We do not know who among us carries the virus that causes AIDS; symptoms may not become visible for years after infection. Yet, we do know that the numbers of people potentially afflicted are staggering. There is no cure, no miracle vaccine, in sight.

Inevitably, some people infected with the AIDS virus¹ will be married, parents, and involved in disintegrating relationships with their spouses. AIDS-related problems will be a focal point of their divorces. Indeed, such cases are beginning to be reported.²

A narrow purpose of this article is to preliminarily explore the impact of AIDS on divorce law: the grounds for divorce, discovery, property distribution, maintenance, child support, custody and pretrial procedure. The article's aim, however, is broader than simply analyzing and applying legal doctrine. By analyzing the impact of AIDS on divorce, it seeks to highlight fundamental questions about the purposes of divorce law and procedure.

A. AIDS and Fault Divorce

How well the system of divorce law and procedure responds to the AIDS crisis is a measure of how well its underlying purposes have been articulated by the legislature and understood by counsel and the courts. The purposes of divorce law and procedure, however, are inherently conflicted.

One set of purposes is based on the traditional assumptions of "fault" divorce: divorce should be reserved for the innocent person whose spouse has committed a serious marital wrong. The fault theory is that the "guilty"

1. The scientific name for the virus that causes AIDS (as well as other diseases, *see* text at note 20, *infra*) is the human immunodeficiency virus (HIV virus). This virus has previously had other names, including human T-lymphotropic virus type III (HTLV-III), lymphadenopathy associated virus (LAV) or AIDS-related virus. HIV is the designation for the virus recently approved by an international committee of scientists for purposes of promoting uniformity. N.Y. STATE DEP'T OF HEALTH, ACQUIRED IMMUNE DEFICIENCY SYNDROME: 100 QUESTIONS AND ANSWERS ABOUT AIDS 1 (1985) [hereinafter AIDS QUESTIONS AND ANSWERS]. In this article the terms HIV virus and AIDS virus are used interchangeably.

2. *See* Anne D. v. Raymond D., 139 Misc. 2d 718, 528 N.Y.S.2d 775 (Sup. Ct. 1988) (denying AIDS test of defendant spouse in divorce action based on claim she had committed adultery); Doe v. Roe, 139 Misc. 2d 209, 526 N.Y.S.2d 718 (N.Y. Sup. Ct. 1988) (AIDS test request denied in custody dispute with in-laws); "Jane" W. v. "John" W., 137 Misc. 2d 24, 519 N.Y.S.2d 603 (Sup. Ct. 1987) (visitation granted to HIV-positive parent); Stewart v. Stewart, 521 N.E.2d 956 (Ind. Ct. App. 1988) (visitation granted to HIV-positive parent).

spouse should be punished in divorce-related economic and custody decision making.³

A different set of purposes underlying the idea of "no-fault" divorce, views divorce as a regrettable, but necessary legal recognition of marital failure. The cause of marital breakdown is generally viewed not as the behavior of one spouse or the other, but both. The economic and custody decisions that divorce requires are, under this view, a problem in managing and minimizing the effects of tragedy, not fixing punishment.⁴

The divorce law and procedure of each state is an admixture of the fault and no-fault views in varying proportions.⁵ This confusion of purpose is perhaps inevitable when divorce laws are created by a political system that emphasizes compromise and practicality, while at the same time, divorce and fault are subjects on which views are intense and frequently influenced by religious beliefs.

AIDS, however, presents a difficult conceptual problem for a mixed fault and no-fault divorce system. It is possible to view infection with the AIDS virus as punishment for morally reprehensible acts, such as adultery and intravenous drug use, and apply divorce doctrine punitively.⁶ On the other hand, when a spouse/parent is infected with the AIDS virus there are significant emotional and financial effects on a family undergoing divorce that require careful and sympathetic management.

One thesis of this article is that an AIDS-infected spouse should not be punished through application of divorce law solely because of his or her infection. Rather, the behavior that resulted in infection and the spouse's actions after learning of it must be assessed for moral blameworthiness and in the total context of the marriage relationship.

A spouse who becomes infected with the AIDS virus "innocently" or takes steps to minimize the risk of transmission to his or her family after learning of infection does not deserve moral blame or punishment. A

3. See generally C. FOOTE, R. LEVY & F. SANDER, *CASES AND MATERIALS ON FAMILY LAW* 1073-1101 (2d ed. 1976) (containing an imaginary dialogue on divorce policy among a bishop, a law professor and a doctor, with the bishop articulating the rationale for a fault divorce system); M. WHEELER, *NO-FAULT DIVORCE* (1974) (providing an overview of the history and policy basis of divorce reform); M. GLENDON, *ABORTION AND DIVORCE IN WESTERN LAW* 64-81 (1987) (cross-cultural perspective) [hereinafter M. GLENDON].

4. See CALIFORNIA GOVERNOR'S COMMISSION ON THE FAMILY, *REPORT* (1966) (generally considered the landmark event in the United States in the development of the no-fault approach to divorce). Professor Herma Hill Kay, one of the members of the California Commission, recently described the history of the Commission's report and evaluated its effects in *Equality and Difference: A Perspective on No-Fault Divorce and Its Aftermath*, 56 U. CIN. L. REV. 1 (1987).

5. In their most recent annual survey, Freed and Walker report that twenty states retain the traditional grounds for divorce in addition to one or more no-fault grounds. Freed & Walker, *Family Law in the Fifty States: An Overview*, 21 FAM. L.Q. 417, 441-42 (1988) [hereinafter Freed & Walker].

6. See Dolgin, *AIDS: Social Meanings and Legal Ramifications*, 14 HOFSTRA L. REV. 193, 197 (1985) (describing AIDS as a "master illness" in which a "metaphor of causation" is based on a theory of "individual excesses and imbalance").

similarly infected spouse who deliberately or negligently engages in high-risk behavior which increased the risk of his own infection or increases the possibility of transmission of the AIDS virus to an unknowing and unconsenting spouse or child is in a different moral category.⁷ In that circumstance, blame and appropriate punishment should be imposed through divorce law, as well as criminal and tort law.

A key issue raised in divorces involving an allegation that a spouse is infected with the AIDS virus is whether he or she can be compelled to undergo an AIDS blood test. Answering this question requires analyzing what use the resulting information would be to a divorce court. Answering this question, in turn, requires an analysis of the role of marital fault in contemporary divorce law.

Resolving the compulsory blood test issue also requires defining a threshold level of evidence that a divorce court should require the spouse seeking the test to produce. A compulsory AIDS blood test in a divorce action challenges the policies that are at the core of public health strategy on how to prevent the further spread of the AIDS virus: confidentiality, voluntary disclosure of infection, and nondiscrimination.⁸

Another thesis of this article is that these public health policies require a divorce court to demand a high level of preliminary evidentiary comfort before a compulsory AIDS blood test is ordered. The spouse seeking the blood test should show more than mere suspicion of HIV infection. Rather, he or she must show to a reasonable certainty that the supposedly infected spouse has engaged in high-risk behavior justifying the label of moral blame appropriate for divorce law to take into account. In effect, the divorce court should ask whether the spouse seeking the involuntary blood test has sufficiently differentiated the "target" spouse from the general population to warrant departure from the general principles of confidentiality and noncoercive testing that are the basis of public health policy.

B. *Managing the Effects of AIDS on the Family Undergoing Divorce*

Beyond questions of marital fault and compulsory testing, a family undergoing divorce with an AIDS-infected spouse must cope with monumental financial and emotional problems. No-fault premises view those problems simply as a magnified version of the problems of tragedy management encountered in every divorce. Another thesis of this article, then, is that the divorce system's aim should be, as far as possible, to generally treat an AIDS-related divorce identically to one in which a spouse has a progressive, fatal disease that does not carry a potential moral stigma.

7. See *infra* notes 56 & 57 and accompanying text.

8. See *infra* note 34 and accompanying text.

1. THE ECONOMIC EFFECTS OF AIDS INFECTION

The economic devastation that AIDS can cause for a family unit are compounded by the financial allocation decisions required by divorce. The fundamental issue is the appropriate balance between family and societal responsibility for the cost of an AIDS patient's medical care. Probably because the allocation questions raised are so difficult, and judicial discretion in divorce-related economic decisions so great, courts have not developed a coherent theory as to how to manage these problems. This article identifies and evaluates several alternative theories to guide divorce-related economic decisions involving an AIDS-infected spouse.

2. AIDS AND CHILD WELFARE

Whether fault or no-fault oriented, all states seek to promote the "best interests of the child" in custody decisions relating to divorce. Under that standard, the custody decision should focus on the child's interest and not overtly or covertly punish the parent for infection with the AIDS virus.

Another thesis of this article is that absent high-risk behavior, a parent's infection with the AIDS virus should not disqualify him or her from custody rights. The AIDS virus is primarily transmitted through sexual intercourse or needle sharing, not acts parents usually engage in with their children. Current research shows there is no realistic danger of transmission of the AIDS virus by "casual contact."⁹ A child does not generally need to be "protected" from a parent with AIDS.

The overwhelming weight of current research supports this view. It is conceivable, though highly improbable, that future research will challenge the conclusion that the AIDS virus is not transmitted by casual contact. Where children are perceived to be at risk, however, it is understandable that estranged parents will argue for absolute assurances of safety in custody arrangements. Courts, however, must make decisions on the facts as they exist, not on litigants' fears. AIDS is simply too new and too complex a disease for medical research to be absolutely definitive. It is "unrealistic and impracticable to measure public health decisions by a no-risk standard."¹⁰ Fact-based decision making is particularly important when constitutionally sensitive and emotionally important interests like the parent-child relationship are at stake.

Rather than seek to isolate an AIDS-infected divorced parent from his or her children, courts should seek to sustain and promote their relationship. The court's goal should be to help the children prepare for their parent's probable deterioration and death through continued contact. With professional help, a continued relationship will hopefully result in greater personal understanding and growth.

9. See *infra* notes 28 and 30 and accompanying text.

10. Schwarz & Schaffer, *AIDS in the Classroom*, 14 HOFSTRA L. REV. 163, 183 (1985).

C. *The Role of Counsel and Procedure in AIDS-Related Divorces*

Counsel have a special responsibility in AIDS-related divorces to be aware of their professional and human obligations to their clients. This article seeks to promote such awareness by analyzing what divorce counsel's ethical obligations are if an AIDS-infected client refuses to disclose his or her medical condition to an unsuspecting spouse. There is no easy answer to this dilemma, though the article makes some suggestions for the considerations that might go into formulating one.

A final thesis of this article is that AIDS-related divorce and custody disputes are generally inappropriate for traditional adversary divorce procedure.¹¹ Conceiving the problem of AIDS and divorce as an exercise in fault-finding makes it difficult, if not impossible, for the dissolving family unit to plan cooperatively to cope with the problems arising from the dual tragedies of death and divorce. The family unit needs emotional and financial bolstering, not the further disintegration caused by an adversary trial.¹²

II. Organization

This article is organized around two hypothetical cases of an AIDS-involved family undergoing divorce. The cases attempt to describe not only the relevant facts from which courts and lawyers must make decisions and arguments, but also something of the emotional background of the dissolving family units.¹³

Both case studies are set in New York and the analysis of them applies New York law. This choice is appropriate because of the large number of AIDS-infected people in New York.¹⁴ It is also appropriate because the highly developed body of statutory and case law regulating divorce in New York reflects a mixture of fault and no-fault premises. Thus, it is possible in discussing how New York law could deal with an AIDS-involved divorce to address problems and issues broadly applicable to many states.

Before the case studies, this article provides a brief overview of essential medical facts concerning AIDS. The footnotes provide additional elabo-

11. See Schepard, *Taking Children Seriously: Promoting Cooperative Custody After Divorce*, 64 TEX. L. REV. 687, 752-70 (1985) (describing a "cooperative custody" dispute resolution system which uses judicially supervised mediation and neutral expert evaluations to promote postdivorce parental cooperation) [hereinafter Schepard, *Cooperative Custody*].

12. *Id.* at 735-43.

13. The case studies are not "representative" of AIDS divorces or patients in any sense. Rather, they are constructed to raise key legal issues which arise when AIDS and divorce become intertwined.

14. See *infra* notes 23 and 25.

ration and references for the reader who wants more technical background about the disease.

The first cases study, that of the hypothetical Rodgers family, involves a bisexual male parent whose wife suspects him of being infected with the AIDS virus. He denies adultery or any other high-risk behavior, and the wife has no reliable proof to the contrary. The husband also exhibits no clinical symptoms of AIDS or ARC.

The Rodgers case study is the vehicle for discussing whether an involuntary AIDS blood test should be ordered in a divorce action. This discussion necessarily requires a preliminary analysis of how HIV infection relates to determinations of marital fault and how such determinations are relevant to issues of grounds for divorce, economic distributions and custody.

In the Billings family case study, a spouse/parent contracts the AIDS virus because of a laboratory accident. The relationship between the spouses disintegrates despite the infected spouse's candor and good faith. The spouses agree to divorce, but disagree over economic and custody issues. Through this case study, this article discusses how "innocent" infection with the AIDS virus should be taken into account on economic determinations relating to divorce—the division of marital assets, maintenance and child support—and custody issues.

The final section of this article discusses the procedures for dispute resolution in AIDS divorce cases. It addresses the special ethical responsibilities of counsel in such matters. This article then makes recommendations for the procedures courts should use in AIDS-related divorces. Finally, it describes an agenda for legislative change of divorce law and procedure suggested by the divorce system's interaction with AIDS.

III. Basic Medical Facts About AIDS

A. Definitions and Symptoms

Acquired Immunodeficiency Syndrome (AIDS) is not a single disease but a spectrum of conditions resulting from infection with the Human Immunodeficiency Virus (HIV virus). The HIV virus attacks the body's immune system, making it less able to combat disease. The HIV virus causes a range of manifestations in exposed people. The nature of the manifestations, not infection with the virus, determines whether the infected person has AIDS.¹⁵

15. The classification of HIV-related diseases in this article draws on a similar classification of a recent Committee Report of the Association of the Bar of the City of New York, which in turn adopted its classification system from a National Institute of Justice Report. Joint Subcommittee on AIDS in the Criminal Justice System, of the Committee on Corrections and Committee on Criminal Justice Operations and Budget, National Inst. of Justice, *AIDS and the Criminal Justice System: A Preliminary Report and Recommendations*, 42 REC. A.B. CITY N.Y. 901, 902 (1987) [hereinafter *AIDS and the Criminal Justice System*]. The classification system is consistent with the Centers for Disease Control's definition of AIDS.

1. SEROPOSITIVITY, SEROCONVERSION AND BLOOD TESTING

Seroconversion is that point in time when antibodies (substances produced in the blood to fight disease organisms) to the HIV virus first become detectable by a blood test.¹⁶ A seropositive person is someone who is seroconverted.

A seropositive blood test does not show that a person has AIDS or any other disease caused by HIV infection, or will develop one in the future. It shows only that he has been exposed to the HIV virus and presumably is infected.¹⁷ At the time of seroconversion the infected person may exhibit a short-term flu-like illness or may show no symptoms at all (asymptomatic).

The time between exposure to the HIV virus and a seropositive antibody test is usually two months, but can range up to twelve months.¹⁸ The blood test produces a small percentage of false positive (and negative) results.¹⁹ Health authorities believe that seropositive people should consider themselves capable of transmitting the HIV virus to others through sexual activity, needle sharing or pregnancy and should take appropriate precautions.

2. HIV INFECTION

This category contains most seroconverted people. They are infected but have no discernable symptoms. Although the immune system of an HIV-infected person has not yet been seriously damaged, abnormalities in laboratory blood tests begin to appear. HIV-infected people may, however, remain asymptomatic for many years. How many of them may eventually develop ARC or AIDS will be discussed below.

16. The blood test actually consists of several stages. First, the blood samples are screened with a commercially prepared, licensed enzyme-linked substance (ELISA). If positive, the sample is retested by an HIV-screening ELISA. If either ELISA sample proves positive, the sample is tested by a different and more precise method, Western blotting. Positive ELISA and Western blot tests can be repeated to ensure accuracy of results. See Burke, *Measurement of the False Positive Rate in a Screening Program for Human Immunodeficiency Virus Infections*, 319 NEW ENG. J. MED. 961 (1988).

17. AIDS QUESTIONS AND ANSWERS, *supra* note 1, at 8.

18. Fisher, *AIDS Update*, 35 HENRY FORD HOSP. MED. J. 5, 7 (1987) [hereinafter *AIDS Update*].

19. After reviewing expert affidavits, a New York trial court recently found that the false positive rate using the ELISA-ELISA-Western Blot Test Series (see Burke, *supra* note 16) for the same blood sample is one false positive for 20,000 tests, an error rate of .005 percent. *Health Ins. Ass'n v. Corcoran*, 531 N.Y.S.2d 456, 459 (Sup. Ct. 1988) (invalidating insurance regulation prohibiting HIV blood testing in applications for health insurance). Compare Meyer & Pauker, *Screening for HIV: Can We Afford the False Positive Rate?* 317 NEW ENG. J. MED. 238 (1987) (suggesting that because of quality control problems false positive rate is likely to be too high to justify mass HIV screening) with Burke, *supra* note 16, at 961 (carefully controlled mass screening program can have an acceptably low false positive rate).

3. ARC (AIDS RELATED COMPLEX)

This somewhat elastic category includes HIV-infected people with a range of clinical symptoms and conditions that show evidence of their infection. However, it does not include people with the "opportunistic diseases" included within the Center for Disease Controls' definition of AIDS.²⁰

4. AIDS

Patients with AIDS generally test seropositive for the HIV virus, show changes of their immune system in laboratory tests, show symptoms of opportunistic infection or other serious diseases that indicate underlying cellular immunodeficiency (e.g., Kaposi's sarcoma, a malignant form of skin cancer or pneumocystis carinii, a severe lung infection), and have no other explanation for their conditions.

Thirty to 40 percent of AIDS patients show symptoms of brain disease or damage to the spinal cord. Psychotic episodes may appear, and motor and coordination changes are seen quite frequently.²¹ Not all the symptoms, however, are the result of the HIV virus infection of brain or nerve tissues; some are related to the opportunistic infections that define AIDS. Also, certain drugs used to treat these opportunistic infections may affect mental functioning, causing hallucinations or changes in personality.

B. Incidence

The size of the HIV-infected population can only be estimated.²² The "conversion rate" from asymptomatic infection to clinical symptoms is the subject of intensive study and informed speculation.²³

In 1987 the American Medical Association reported that the number of HIV-infected people in the United States "may number 1.5 million, approximately 35,000 of whom have been reported to suffer from AIDS and more than 20,000 of whom are dead."²⁴ Recently, federal public

20. *AIDS and the Criminal Justice System*, *supra* note 15, at 903. For a discussion of the elasticity of the definition of ARC, see *AIDS Update*, *supra* note 18, at 11 (arguing that ARC has no generally agreed on medical definition and that the term should be reserved for "those with severe symptoms, prodromal infections or severe immune deficiency as manifested by T-helper cell counts under 200/mm").

21. Beckett, Summergrad & Manschreck, *Symptomatic HIV Infection of the CNS in a Patient Without Clinical Evidence of Immune Deficiency*, 144 AM. J. PSYCHIATRY 1342 (1987).

22. Board of Trustees, American Medical Association, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 J. A.M.A. 2097, 2102 (1987) [hereinafter *AMA AIDS Report*].

23. *Id.* at 2102-03. The speculative nature of estimates of the total number of HIV-infected people is illustrated by New York City's recent "downward" modification of the number of HIV-infected residents, previously estimated at 400,000 or about 1 in 18 residents. N.Y. Times, July 14, 1988, at B1, col. 2. Health officials recently revised the number to 250,000 based on a "reduction" of the estimated population of homosexual men. N.Y. Times, July 20, 1988, at A1, col. 1. See also N.Y. Times, July 22, 1988, at B4, col. 2 (describing the difficulties of making accurate estimates of the scope of HIV infection).

24. *AMA AIDS Report*, *supra* note 22, at 2097.

health officials have revised their estimates upward and predict that at least 450,000 Americans will be diagnosed as having AIDS by the end of 1993 and as many as 100,000 new cases will be reported in that year alone.²⁵

C. Prognosis and Treatment

There is no cure for AIDS and no vaccine that will stop the spread of the HIV virus. Only a single drug, AZT, has been licensed to treat infection with the HIV virus itself, although other drugs are available to treat the opportunistic infections that help define AIDS. AZT prolongs life in some patients, but is highly toxic. Another group of AIDS-related drugs is under experimental study. The Food and Drug Administration recently projected, however, that these experiments were unlikely to yield more than one or two new useful drugs before 1991.²⁶

Approximately 60 percent of all patients diagnosed as having AIDS have died. The death rate increases to more than 70 percent two years after diagnosis; some people, however, are still alive after seven years.²⁷

D. Transmission

Current research establishes that HIV infection is primarily transmitted through homosexual sexual acts or the sharing of contaminated needles by intravenous drug users. It can also be transmitted via heterosexual sexual acts, blood transfusions, or from pregnant mothers to their fetuses.²⁸

Unlike the viruses that cause most transmissible diseases—cold, flu, measles, etc.—the HIV virus is *not* transmitted through sneezing, coughing, eating or drinking from common utensils, or merely being around an

25. The figures are not yet formally published, but have been reported in the newspapers. N.Y. Times, July 14, 1988, at B9, col. 4. Recently, researchers at the Centers for Disease Control issued a report projecting that 99 percent of HIV-infected people will eventually develop ARC or AIDS. This projection is based on a mathematical model drawn from a sample of gay men in San Francisco. Not all medical experts agree with this figure but, as stated by New York City Health Commissioner Dr. Steven Joseph: "The 99 percent projection reinforces all our pessimism both for individuals and the drain on resources. I don't know anybody in the field who does not agree that eventually the overwhelming percentage of infected people will have serious if not severe symptomology, in the high 80's, 90's—as close to universal as you can get in medicine." *Id.* at col. 8.

AIDS sufferers are more highly concentrated in urban areas. As of July 1988, more than 14,000 New York City residents have been diagnosed as having AIDS. N.Y. Times, July 20, 1988, at A1, col. 1. "In New York City, AIDS is the leading cause of death among men 25 to 44 years old and women 25 to 34. . . . Of the persons in whom AIDS was diagnosed before 1983, 87 percent are dead." Weinberg & Murray, *Coping with AIDS: The Special Problems of New York City*, 317 NEW ENG. J. MED. 1469, 1470 (1987).

26. N.Y. Times, July 14, 1988, at B9, cols. 1–3.

27. AIDS QUESTIONS AND ANSWERS, *supra* note 1, at 10.

28. AIDS Update, *supra* note 18, at 7–8.

infected person.²⁹ An ongoing study at Montefiore Hospital in New York, one of many confirming that the HIV virus is not transmitted through "casual contact," is described in a recent article:

These AIDS patients [the ones involved in the study] are mostly poor, Hispanic, intravenous drug abusers living in very crowded conditions in New York City—certainly not an optimal situation regarding household hygiene. A total of 199 of these household contacts have been studied. Ninety percent of these contacts had shared the bathroom and kitchen. Fifty percent had drunk from the same glass or eaten from the same dish before it had been washed. Thirty to 40 percent had slept in the same bed (mostly children sleeping with their parents) and bathed with the patient. Ten to 15 percent used items that might draw blood such as razors, toothbrushes, or nail clippers. Eighty-three percent kissed on the cheek and seventeen percent kissed on the lips. That none of these 199 nonsexual household members is seropositive is strong evidence against close personal contact short of sexual relations transmitting HIV.³⁰

E. Risk Groups

Approximately 95 percent of the AIDS cases in New York occur among the following groups: 58 percent are homosexual or bisexual men, 5 percent of whom have used intravenous drugs; 31 percent are male and female intravenous drug users; 2 percent are heterosexual partners of person with AIDS or at risk for AIDS; 2 percent are children who acquired AIDS from infected mothers; and 1 percent are hemophiliacs or others who received AIDS from transfusions of infected blood.³¹

IV. The Rodgers Family Case Study

Family Composition:	Larry Rodgers	Age 31
	Sharon Rodgers	Age 34
	Rachel Rodgers	Age 3

Larry, the youngest of four boys, was born in a small town in West Virginia. His father, a local banker, was considered a leader in the

29. See *AMA AIDS Report*, *supra* note 22, at 2100 ("The transmission of the AIDS virus does not occur through casual contacts"); Fischl, Dickinson, Scott, Klimas, Fletcher & Parks, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 J. A.M.A. 640, 644 (1987) (detailed study of households and families with an adult AIDS patient shows that the HIV virus "is not spread through close contact other than intimate sexual or blood exposures"). Courts that have allowed HIV-infected children to attend school with their peers have made identical findings. See *Ray v. School Dist.*, 666 F. Supp. 1524, 1530-31 (M.D. Fla. 1987); *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376, 380 (C.D. Cal. 1986); *District 27 Community School Bd. v. Board of Educ.*, 130 Misc. 2d 398, 403-08, 502 N.Y.S.2d 325, 330-32 (Sup. Ct. 1986).

30. *AIDS Update*, *supra* note 18, at 8.

31. AIDS QUESTIONS AND ANSWERS, *supra* note 1, at 1.

community. His mother was a traditional housewife and active in volunteer activities.

His parents and teachers described Larry as being more "sensitive" than his brothers. He did well in school and was well liked by his teachers. He felt uncomfortable with other young boys, and tended to stay indoors after school, drawing, watching TV, or helping his mother prepare the evening meal. He was in a few fights at school, and was teased as being a sissy.

Larry went to the University of West Virginia on full scholarship. Upon graduation, he moved to New York City and entered the Pace School of Architecture, where he majored in Design.

Larry dated occasionally throughout high school and college. Being physically attractive, he was pursued by several female classmates. During his junior year, he had his first of three homosexual encounters, which lasted for a few weeks. He felt bewildered and ashamed by these involvements, and upon coming to New York entered psychotherapy to better understand these impulses and the distress it caused him.

After graduation, Larry joined a small architectural firm and was quite successful. He met his future wife while consulting with her brokerage firm about alterations of her office. He married her at the same time he left therapy.

Sharon was born and raised in Wilton, Connecticut. She was an only child, and was adored by both her parents. Her father, a corporate lawyer, was a senior partner in a small law firm, and retired to Florida with her mother.

Sharon, who received a degree in accounting, was married for the first time at age twenty-two. This marriage lasted for about one year and ended after her husband, who was abusing cocaine, beat her severely.

Since that time Sharon stayed away from serious involvements and focused on her career with a Wall Street brokerage firm. She met Larry when she was twenty-eight and found his physical attractiveness and gentle sensitivity appealing. They married intending to have a child soon, as Sharon was beginning to worry about the ticking of her biological clock. Rachel was born eleven months later.

Although both parents love Rachel, Larry found himself spending more time with her than Sharon. Sharon returned to work after six weeks of maternity leave. Larry, without much fanfare, moved much of his work to an office he set up in their suburban home.

As time went on, although he felt much affection for Sharon, who seemed to commute, run the house, and organize everyone with great competence, he began losing sexual interest in her. In fact, their sexual relationship never got back on track after Rachel's birth. Larry's dreams were frankly homosexual in content, which worried him.

In the second year of marriage, Larry found himself going to gay

bars after work. He would feel enormously guilty about his feelings and desires in the presence of male homosexuals. He tried to compensate for his lack of passion for Sharon by showering affection on Rachel.

Sharon and Larry began to argue about the lack of sex in their marriage. Prompted by a neighbor friend, Sharon consulted a lawyer. Larry had told Sharon that he had homosexual experiences prior to their marriage. She told her attorney about these incidents, who in turn hired a private detective to follow Larry. The detective observed Larry in gay bars but never in an extramarital sexual relationship.

After hearing the detective's report, Sharon confronted Larry, who denied any adulterous activity. Larry also refused to take an HIV blood test, as Sharon requested. Simultaneously furious and frightened, Sharon filed for divorce. Her own HIV blood test proved negative. Immediately after Larry answered her divorce complaint, Sharon filed a motion to compel Larry to undergo an HIV blood test.

V. Divorce and Involuntary AIDS Blood Testing

The central issue raised by Sharon's motion is whether the state can compel Larry to undergo a blood test for a fatal, socially stigmatizing infection because Sharon has filed an action for divorce. Sharon has fears and suspicions of possible HIV infection based on Larry's premarriage homosexual behavior and presence in gay bars. Sharon, however, has no evidence that Larry is HIV-infected and he denies that he is infected. Nor does Sharon have proof that Larry has engaged in high-risk sexual activity or other conduct increasing his risk of becoming HIV-infected since their marriage.

Sharon's interest in finding out information relevant to her own health is generally not implicated by her motion. She is presently seronegative. A current seronegative test of Larry does not guarantee that a future HIV test will yield the same result. Conversely, a seropositive test result for Larry does not mean that Sharon will also eventually test seropositive.

The only way Sharon can definitively ascertain whether she or she is not seroconverted is to be regularly retested at periodic intervals. Unlike other sexual partners of Larry (if there are any), Sharon is aware of the possibility that Larry might be seropositive. She thus does not need to be warned to have herself tested and not to engage in high-risk activity with others.

On the other hand, Larry's interest in bodily integrity and privacy will be invaded by the involuntary blood test Sharon seeks.³² This interest is

32. These interests do not, however, in a civil case, seem to rise to constitutional proportions. Cf. *Bowerman v. MacDonald*, 431 Mich. 1, 427 N.W.2d 477, 485 (1988) (paternity blood tests may be ordered without prior search warrant or hearing) (court notes that its research has not revealed any cases in which properly constituted discovery in a civil action violated Fourth Amendment prohibition against unreasonable searches and seizures).

entitled to more recognition than in the typical personal injury case in which medical examinations are routinely ordered. In those cases, the plaintiff voluntarily seeks affirmative relief (such as damages) from the court because of his or her medical condition.³³ The defendant and the court cannot verify the plaintiff's claim for relief without a medical examination. By filing suit, the plaintiff thus waives some of his interest in privacy by voluntarily putting his medical condition into issue.

Larry has not, however, voluntarily asked a court for relief. Rather, his interest in bodily integrity and privacy is threatened because Sharon invokes the coercive power of the state against Larry by filing for divorce against Larry's wishes.

Also weighing heavily against testing Larry involuntarily is the public health interest in controlling the spread of AIDS. Public health strategy seeks to limit the spread of the HIV virus by encouraging voluntary testing, voluntary disclosure of infection to sexual partners, and voluntary abstinence from high-risk behavior. This strategy is implemented by assuring AIDS victims of confidentiality and nondiscrimination.³⁴

Another interest the court could weigh in the decision whether to compel Larry to take an HIV blood test is the desirability of encouraging Larry and Sharon to settle their differences through private ordering. Should Larry ultimately develop AIDS or ARC, Larry, Sharon and Rachel face the monumental task of coping with the emotional and financial implications of Larry's probable deterioration and death at the same time they are coping with divorce. Larry's failure to take a blood test voluntarily surely infuriated Sharon. Sharon's attempt to force Larry to do so

33. *Koump v. Smith*, 25 N.Y.2d 287, 250 N.E.2d 857, 303 N.Y.S.2d 858 (1969).

34. *E.g.*, Draft Report of the Chairman of the President's Commission on the Human Immunodeficiency Virus Epidemic excerpts reprinted in the N.Y. Times, June 3, 1988, at 30, col. 4 [hereinafter President's AIDS Commission Report]; *AMA AIDS Report*, *supra* note 20, at 2101-02; NEW YORK STATE DEP'T OF HEALTH, A PHYSICIAN'S GUIDE TO AIDS: ISSUES IN THE MEDICAL OFFICE 5 (1988). New York State's new landmark legislation regulating HIV testing (*see infra* note 41) contains the following statement of legislative intent:

The legislature recognizes that maximum confidentiality protection for information related to human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) is an essential public health measure. In order to retain the full trust and confidence of people at risk, the state has an interest both in assuring that HIV related information is not improperly disclosed and in having clear and certain rules for the disclosure of such information. By providing additional protection for the confidentiality of HIV related information, the legislature intends to encourage the expansion of voluntary confidential testing for the [HIV] virus so that individuals may come forward, learn their health status, make decisions regarding the appropriate treatment, and change the behavior that puts them and others at risk of infection.

The legislature also recognizes that strong confidentiality protections can limit the risk of discrimination and the harm to an individual's interest in privacy that unauthorized disclosure of HIV related information can cause. It is the intent of the legislature that exceptions to the general rule of confidentiality of HIV related information be strictly construed.

1988 N.Y. LAWS ch. 584 § 1 (McKinney).

has the identical effect on him. The result is to discourage future cooperation and communication between them.

Recrimination of the type Larry and Sharon's controversy over testing engenders can destroy whatever modicum of cooperation might otherwise be possible between Larry and Sharon.³⁵ The rules of law courts articulate in AIDS-related divorces will either encourage or discourage lawyers from raising the level of acrimony in pretrial proceedings and settlement negotiations.³⁶

Balanced against the potential harm that might result from an involuntary blood test is the potential gain of discovery of relevant information for the divorce court. There are three possible issues on which Larry's HIV blood test result might produce probative evidence: marital fault, economic distribution, and child custody. To understand the balance of interests on the testing motion requires analysis of how a finding that Larry is seropositive might influence the court's determination of each.

A. Grounds For Divorce

New York is a fault divorce state that also permits divorce by mutual consent. Fault need not be established if the parties separate for a year or more pursuant to a written separation agreement.³⁷ Absent such agreement, to obtain a judgment of separation leading to divorce,³⁸ or divorce, a spouse must establish marital fault.

Essentially, if Larry will not consent to a divorce, Sharon must prove that he committed adultery, treated her in a "cruel and inhuman" manner, or "abandoned" the marital relationship.³⁹

Civil Practice Law and Rules (CPLR) § 3121,⁴⁰ the relevant New York

35. See *McMahan v. McMahan*, 100 A.D.2d 826, 827, 474 N.Y.S.2d 974, 974-75 (1984) (explaining reasons for rule disallowing pretrial discovery on marital fault):

[I]n most instances, other than to exacerbate an already frequently acrimonious relationship, no purpose would be served in allowing discovery of the various charge and countercharge of misconduct which an estranged husband and wife engage in hurling at each other. Whatever possibility there might exist for the couple involved in this litigation to be able to deal courteously with each other in the future, if only for the sake of their children, would be rendered even more unlikely by further exploration into specific acts of wrongdoing.

36. See generally, Mnookin & Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979) (discussing the impact of substantive and procedural rules on negotiation of divorce settlements).

37. N.Y. DOM. REL. LAW § 170(5)-(6) (McKinney 1988).

38. *Id.* § 200 (McKinney 1988).

39. *Id.* § 170(1)-(6) (McKinney 1988).

40. N.Y. CIV. PRAC. L. & R. § 3121 (McKinney 1988).

statute,⁴¹ on its face, seems to authorize involuntary blood testing in matrimonial matters.⁴² The statute thus suggests that an HIV blood test could be an appropriate form of pretrial discovery to establish evidence of marital fault.

Two lines of precedent, however, limit the apparently broad authorization of the statute. First, two of the four New York appellate divisions do not allow pretrial disclosure on subjects related to marital fault.⁴³ Second, despite the statutory authorization for involuntary medical examinations, the courts, based on the potential for abuse, have often issued protective orders.⁴⁴

Both of these lines of precedent reflect judicial discomfort with the logical implications of the fault divorce system. In effect, they are statements that the courts will not allow counsel and litigants to take marital fault theories to the point of allowing potentially harassing discovery and invasions of privacy.

The cases thus require a careful balancing of the gain in relevant information that might result if Larry is ordered to submit to an HIV blood test against the resulting costs. The best way to analyze that question is

41. New York State recently enacted landmark legislation regulating HIV testing. The statute generally requires informed consent before an HIV test is administered and pre- and posttest counseling. It generally requires confidentiality of HIV-related information, with disclosure permitted in narrowly defined "need to know" circumstances. The statute also sets standards and procedures under which a physician may disclose HIV-related information to the sexual partner of a tested person. 1988 N.Y. LAWS ch. 584 (McKinney). The new law, however, specifically exempts tests ordered under CPLR § 3121 from its scope. *Id.* § 2781 1.

42. See *Golser v. Golser*, 115 A.D.2d 695, 698, 496 N.Y.S.2d 521, 524 (1985). *Cf.* *Boyles v. Boyles*, 119 Misc. 2d 16, 462 N.Y.S.2d 736 (Fam. Ct. 1983) (allowing results of blood test into evidence in custody proceeding where paternity is questioned).

43. *Van Ess v. Van Ess*, 100 A.D.2d 848, 848, 474 N.Y.S.2d 90, 91 (2d Dep't 1984). See *Corsel v. Corsel*, 133 A.D.2d 604, 519 N.Y.S.2d 710 (2d Dep't 1987); *McMahan v. McMahan*, 100 A.D.2d 826, 474 N.Y.S.2d 974 (1st Dep't 1984). In the Third Appellate Department, restrictions on pretrial disclosure concerning matrimonial fault are "left to individual protective orders to prevent abuse, rather than embodied in a blanket prohibition." *Nigro v. Nigro*, 121 A.D.2d 833, 834, 504 N.Y.S.2d 264, 265 (3d Dep't 1986). See *Semon v. Saridis*, 125 A.D.2d 882, 882, 510 N.Y.S.2d 236 (3d Dep't 1986). The New York Court of Appeals has not resolved this conflict in the lower appellate courts.

44. The leading case is *Wegman v. Wegman*, 37 N.Y.2d 940, 343 N.E.2d 288, 380 N.Y.S.2d 649 (1975), in which the New York Court of Appeals said:

CPLR 3121 does not prohibit [medical] examinations in matrimonial proceedings, and although we recognize the potential for abuse in these cases, the court's broad discretionary power to grant a protective order to prevent unreasonable annoyance, expense, embarrassment, disadvantage, or any other prejudice to any person or the courts (CPLR 3103) should provide adequate safeguards. (Emphasis added.)

Other courts, following *Wegman*, have recognized the potential for harassment and abuse in section 3121 examinations in matrimonial actions, and have carefully limited the conditions under which they will allow them. *E.g.*, *Lohmiller v. Lohmiller*, 118 A.D.2d 760, 760, 500 N.Y.S.2d 151, 152 (1986) (section 3121 "applies to matrimonial actions, but the potential for abuse is so great in these actions that the court is given broad discretionary power to grant a protective order. . . ."); *Rosenblitt v. Rosenblitt*, 107 A.D.2d 292, 294, 486 N.Y.S.2d 741, 743 (1985) (same).

to assume for the moment that a blood test would show that Larry is seroconverted. What use would such evidence be to Sharon's pleading and proof of any of the fault grounds?⁴⁵

1. ADULTERY

Adultery is "the commission of an act of sexual or deviate sexual intercourse, voluntarily performed by the defendant, with a person other than the plaintiff after the marriage of plaintiff and defendant."⁴⁶

Assume that Sharon seeks to introduce Larry's seropositive blood test into evidence. She argues that the HIV virus is transmitted by sexual intercourse, and that she is seronegative. Larry, therefore, must have become infected because of sexual intercourse with someone other than her. The blood test result, therefore, is proof of Larry's adultery.

Questions under the law of evidence would arise from the offer of proof of Larry's blood test results. Sharon would have to show that the HIV testing procedure has gained general scientific acceptance. Larry would also have to be offered the chance to show that the specific procedures used in his test were either defective or empirically unacceptable.⁴⁷ The court might reject the offer of proof because of general concerns about the reliability of the blood test, which does have a small false positive rate, or how it was administered in Larry's particular case.⁴⁸

Even if admissible into evidence, a seropositive blood test does not conclusively establish that Larry committed adultery. It is possible that the virus was transmitted through needle sharing or blood transfusion. Nor does a seropositive blood test establish the time of transmission and any act of sexual intercourse that may be related to it. However, since the most common transmission method is through sexual intercourse, Sharon's counsel might argue that seropositivity has some probative, though

45. The scope of pretrial discovery is, of course, broader than the scope of evidence admissible at trial. A litigant is entitled to pretrial discovery of "all evidence material and necessary in the prosecution or defense of an action, regardless of the burden of proof." N.Y. CIV. PRAC. L. & R. § 3101(a) (McKinney 1988). The scope of discovery is liberally construed and restricted by a test "for materiality of 'usefulness and reason.'" *Hoenig v. Westphal*, 52 N.Y.2d 605, 608, 422 N.E.2d 491, 492, 439 N.Y.S.2d 831, 832 (1981). CPLR § 3121 broadens the general rule of discovery by making medical reports otherwise protected from discovery by the work product rule discoverable. *Id.* However, the scope of pretrial discovery is not unlimited, especially where important privacy and public health interests are at stake.

46. N.Y. DOM. REL. LAW § 170(4) (McKinney 1988). "An extramarital homosexual act, like a heterosexual act, may . . . be grounds for divorce, based on adultery." "M.V.R." v. "T.M.R.", 115 Misc. 2d 674, 680, n.11, 454 N.Y.S.2d 779, 783, n.11 (Sup. Ct. 1982).

47. *Burgel v. Burgel*, 141 A.D.2d 213, 533 N.Y.S.2d 735 (1988) (dissenting opinion) (dictum) (upholding trial court order granting motion requiring mother in child custody dispute to provide hair sample for radioimmunoassay test for cocaine use). See generally J. WEINSTEIN, J. MANSFIELD, N. ABRAMS & M. BERGER, *EVIDENCE: CASES AND MATERIALS* 40-53 (7th ed. 1983) for a collection of materials on the problems of admitting blood test results into evidence.

48. See *supra* notes 16 & 19.

not conclusive, evidentiary value in support of Sharon's adultery claim.⁴⁹

Whatever probative value the blood test result may have, however, is far outweighed by its prejudicial effect on public health strategy and Larry. Admission of the blood test result will cause Larry to fear he will be revealed to be HIV positive to colleagues at work, family and friends by Sharon or her lawyer and discriminated against as a result.⁵⁰ Thus, others who believe themselves to be possibly HIV infected will be less likely to cooperate with voluntary testing.⁵¹

The HIV test results could also prejudice fair determination of Larry's denials of adultery. In New York, Sharon is entitled to a jury trial on her adultery claim and all marital fault grounds.⁵² HIV infection is sometimes confused with moral retribution for homosexuality, "deviate" sexual practices and drug addiction. Evidence that a Larry is seropositive might induce a jury to "convict" him of adultery even though he acquired the virus through needle sharing or blood transfusion. Introduction of the seropositive blood test into evidence is an invitation to the jury to pin a scarlet "A" on Larry without carefully distinguishing whether it stands for adultery or AIDS.

Finally, admission of the blood test results will only exacerbate the deteriorating relationship between Larry and Sharon, making planning for the future on a cooperative basis almost impossible.

Sharon should thus be required to prove adultery by more traditional means (e.g., hiring a private detective or tapping Larry's phone) which are less likely to offend the public policy of nondiscrimination against AIDS carriers rather than introducing Larry's blood test into evidence.

49. Cf. *David "CC" v. Rose "GG"*, 530 N.Y.S.2d 335, 336 (App. Div. 1988) (HLA blood test another factor, not a conclusive one, to be received into evidence to establish paternity).

50. Fear of abuse recently led a Kansas judge to issue a permanent injunction barring a husband's doctors from informing his former wife that he tested HIV positive. The couple was separated for two years, did not have sexual relations for more than two years and the husband had no intention of having sexual relations with his wife in the future. The wife, apparently, had expressed an interest in reconciliation. In issuing the injunction the court stated: "The release of John Doe's HIV results may not only subject him to ridicule and contempt of his family and friends and the community at large, but could endanger his job and, consequently, his medical benefits." *Doe v. Prime Health/Kansas City, Inc.*, 15 FAM. L. REP. (BNA) 1027, 1028 (Kan. Dist. Ct. Oct. 18, 1988).

51. E.g., President's AIDS Commission Report, *supra* note 34; AMA AIDS Report, *supra* note 22, at 2098; *Conference Health Experts Rule Out Mandatory Testing*, 2 AIDS POL'Y & LAW No. 4 (March 11, 1987) (reporting consensus results of national conference convened by federal public health officials). See *South Florida Blood Service, Inc. v. Rasmussen*, 467 So. 2d 798, 802 (Fla. Dist. Ct. App. 1985) (denying disclosure of names of blood bank donors to plaintiff who alleged the transmission of the HIV virus through a blood transfusion) ("AIDS is the modern day equivalent of leprosy. AIDS, or a mere suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment").

52. N.Y. DOM. REL. LAW § 173 (McKinney 1988).

2. CRUEL AND INHUMAN TREATMENT

Sharon might next argue that Larry's seropositive blood test could be probative evidence of his "cruel and inhuman" treatment of her. The statute defines the term as "conduct of the defendant . . . [that] so endangers the physical or mental well-being of the plaintiff as renders it unsafe or improper to cohabit with the defendant."⁵³

Judicial construction has not fleshed out the contours of this vague language. "Cruel and inhuman treatment" is not necessarily limited to criminal or tortious conduct of one spouse toward the other. Rather, courts attempt to distinguish between "serious misconduct" which qualifies as cruel and inhuman treatment and "mere incompatibility" which does not.⁵⁴ To establish cruel and inhuman treatment Sharon must "generally show a course of conduct by [Larry] which is harmful to the physical or mental health of [Sharon] and makes cohabitation unsafe or improper."⁵⁵

Even if Larry is HIV-infected, there is no danger that he will transmit the HIV virus to Sharon through casual contact. It is not "unsafe or improper" for Sharon to presently cohabit with Larry so long as they abstain from high-risk behavior with each other.

Sharon has no evidence that in the past Larry intentionally or negligently increased the risk of transmission of the HIV virus to her. If she had such evidence, however, she could allege a cruel and inhuman treatment claim, and an involuntary blood test might be appropriate. Such conduct might be both a crime and tort,⁵⁶ and also establish grounds for divorce under the "unsafe and improper" standard.⁵⁷

53. *Id.* § 170(1) (McKinney 1988).

54. *Brady v. Brady*, 64 N.Y.2d 339, 476 N.E.2d 290, 486 N.Y.S.2d 891 (1985); *Hessen v. Hessen*, 33 N.Y.2d 406, 308 N.E.2d 891, 353 N.Y.S.2d 421 (1974).

55. *Brady v. Brady*, 64 N.Y.2d 339, 343, 476 N.E.2d 290, 292, 486 N.Y.S.2d 891, 893 (1985).

56. In *Maharam v. Maharam*, 123 A.D.2d 165, 510 N.Y.S.2d 104 (1986), the Appellate Division held that a wife can maintain a tort action against her husband for wrongful transmission of genital herpes on either fraud or negligence theories. In so holding, the court relied on N.Y. PUB. HEALTH LAW § 2307 (McKinney 1985) which provides "Any person who, knowing himself or herself to be infected with an infectious venereal disease, has sexual intercourse with another shall be guilty of a misdemeanor." This statute has not yet been applied to transmission of the HIV virus. It does suggest, however, that deliberately or negligently increasing the risk of transmission of a disease through sexual intercourse violates public policy. See also *R.A.P. v. B.J.P.*, 428 N.W.2d 103 (Minn. Ct. App. 1988) (spouse infected with genital herpes has a legal duty to avoid transmitting the disease to other spouse). A strong moral argument can be made, furthermore, that a person infected with the HIV virus who knowingly fails to warn their sexual partner has acted irresponsibly and should be subject to criminal and tort sanctions. See *AMA AIDS Report*, *supra* note 22, at 2103.

57. Indeed, there are some suggestions in the case law that the intent of the defendant in inflicting the "cruel and inhuman treatment" is not relevant. "[S]ection 170 of the Domestic Relations Law focuses exclusively upon the effect of the conduct complained of and makes no mention of its cause." *Pajak v. Pajak*, 56 N.Y.2d 394, 397, 437 N.E.2d 1138, 1139, 452 N.Y.S.2d 381, 382 (1982) (holding that mental illness is not an affirmative defense to a complaint of cruel and inhuman treatment) (emphasis added).

Sharon must show more than a fear of *possible* infection to successfully plead and prove cruel and inhuman treatment.⁵⁸ Despite her suspicions, she has not documented that Larry has engaged in behavior that puts him in a group at high risk of HIV infection. Nor does Sharon have any evidence of any behavior by Larry that creates even an inference he deliberately or negligently increased the risk of her becoming HIV-infected. All Sharon has shown is that Larry had homosexual sexual encounters in the distant past and has associated with homosexuals in the recent past.

Sharon has thus not yet produced evidence of a credible claim of "cruel and inhuman" treatment. To do so, and to support her request for an involuntary blood test of Larry, Sharon should be required to present a detailed medical affidavit confirming a seropositive HIV virus test and a personal affidavit that she engaged in no high-risk behavior other than sexual relations with Larry.

3. CONSTRUCTIVE ABANDONMENT

A final claim Sharon might make to establish grounds for divorce is that Larry has "abandoned" her. To do so, Sharon must show that Larry abandoned her "for more than one year."⁵⁹ Since Larry still lives in the marital residence he has not abandoned Sharon and Rachel in the conventional sense of the term. Rather, Sharon's claim must be for "constructive abandonment." She must show that Larry has not "fulfill[ed] the basic obligations of the marriage relationship," the legal euphemism for willingness to have sexual intercourse. Sharon must also show "that such conduct [is] unjustified and without the consent of the abandoned spouse."⁶⁰

Larry and Sharon's sexual relationship deteriorated after Rachel's birth. The deterioration was not, however, initially related to Sharon's fear of Larry's possible HIV infection. The facts are unclear, however, as to whether Larry and Sharon have had sexual intercourse during the past year. If they did, Sharon has no claim of constructive abandonment. The resolution of any dispute between Larry and Sharon on this point would be an issue of fact for the jury to decide at trial.

Conversely, Larry might argue that he wants to have sexual relations with Sharon, but she unjustifiably refused, citing his possible HIV infection. Indeed, Larry might try to state a claim for constructive abandonment against Sharon should she refuse a request from him for a sexual

58. A spouse's unsupported fear that her estranged spouse may have infected her with the HIV virus is not sufficient for a tort action. The plaintiff must allege that she has tested seropositive for the HIV virus and that it has in fact been deliberately or negligently transmitted to her by her estranged spouse. *Doe v. Doe*, 136 Misc. 2d 1015, 519 N.Y.S.2d 595 (N.Y. Sup. Ct. 1987).

59. N.Y. DOM. REL. LAW § 170(2) (McKinney 1988).

60. *Frances G. v. Vincent G.*, 133 A.D.2d 254, 254, 519 N.Y.S.2d 147, 148 (1987), *rev'd on other grounds*, 71 N.Y.2d 1001, 525 N.E.2d 739, 530 N.Y.S.2d 93 (1988). See *Casale v. Casale*, 111 A.D.2d 737, 489 N.Y.S.2d 775 (1985).

relationship for a year or more. Sharon would argue her refusal is justified, since Larry might transmit the HIV virus to her through sexual intercourse. Larry might, however, respond that he is willing to use a condom, the proper use of which significantly reduces the risk of HIV transmission.⁶¹ Even if the court accepted Sharon's "justification" argument, however, all it would establish is a defense to Larry's claim of constructive abandonment. Sharon would still not have grounds for divorce.

Generally, an involuntary HIV blood test for Larry will not have much relevance to a claim of constructive abandonment by Sharon. Larry has not raised a constructive abandonment claim against Sharon, so any claim that the HIV test would be relevant to her defense of justification is premature.

A digression is in order. The ironies of the fault system in AIDS divorce cases are clearest in considering Larry and Sharon's possible constructive abandonment claims. If neither can establish constructive abandonment, they stay married. The fault divorce system requires the courts to go through the distasteful process of assigning blame for a decline in a married couple's sex life, an area which should be private and generally free from state examination.⁶² If blame cannot be assigned, divorce is not granted.

Sharon is not Larry's chattel. She should have the right to refuse to have sexual intercourse with him, based on rational or irrational fears for her life. Larry should not have to worry whether his disinclination to have sexual relations with Sharon penalizes him in a divorce action. Rather, if the sexual impasse between Larry and Sharon continues for too long, and counseling does not resolve it, either should have the right to ask the court to dissolve their marriage, without inquiry regarding the reasons why their sex life deteriorated.

B. *Economic Issues*

To some extent, the question whether an involuntary blood test should be ordered to help the court determine grounds for divorce overlaps with the question whether the test should be ordered to provide relevant information on economic issues. Historically, a finding of marital fault was a significant influence on divorce-related economic determinations. A spouse found guilty of marital fault could be denied maintenance. Indeed,

61. See *AIDS Update*, *supra* note 18, at 15 (noting that the HIV virus does not pass through latex condoms and that ideally condoms should be 100 percent protective. Improper use of condoms, however, leads to a 10 percent failure rate for pregnancy, with a similar failure rate for HIV transmission probable.)

62. Cf. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965) (state statute prohibiting married couple from using contraceptives violates right of privacy) ("We deal with a right of privacy older than the Bill of Rights—older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred").

the severe economic consequences of a finding of marital fault was a principal reason the courts required a higher standard of proof for "cruel and inhuman treatment" in long-term marriages.⁶³

The passage of New York's Equitable Distribution Law (EDL)⁶⁴ in 1980 changed the equation between marital fault and divorce-related economic determinations.⁶⁵ While the statute is silent on the role of marital fault in determining property distribution and maintenance, courts have severely circumscribed its relevance to those issues.

Except for conduct that "shocks the conscience of the court," marital misconduct, such as adultery, is generally not relevant to property division at the time of divorce.⁶⁶ About the only conduct of an AIDS-infected spouse that could rise to the "shock of conscience" level is intentionally or negligently increasing the risk of transmission of the disease to family members through high-risk behavior.⁶⁷ Such behavior is morally wrong, and it also depletes marital resources by increasing health care costs and decreasing the ability of the spouse/parents to pursue economically productive activity. A court should take it into account in divorce-related economic distributions. As previously discussed, however, Sharon has not made the necessary showing to establish a probable case of such serious wrongdoing by Larry.

As will be discussed more fully in the Billings case study,⁶⁸ irrespective

63. *Brady v. Brady*, 64 N.Y.2d 339, 476 N.E.2d 290, 486 N.Y.S.2d 891 (1985); *Hessen v. Hessen*, 33 N.Y.2d 406, 308 N.E.2d 891, 353 N.Y.S.2d 421 (1974).

64. N.Y. DOM. REL. LAW § 236B (McKinney 1988).

65. Freed & Walker report that forty-one states have some form of equitable distribution. Freed & Walker, *supra* note 5, at 456. They also report that in the remaining community property states "fault has been significant . . . as to the share of property distribution." *Id.* at 452. For a discussion of the increasingly narrower differences between equitable distribution and community property states see Younger, *Marital Regimes: A Story of Compromise and Demoralization, Together with Criticisms and Suggestions for Reform*, 67 CORNELL L. REV. 45, 66-77 (1981) (describing the partnership theory of marriage as the basis of both systems).

66. *E.g.*, *O'Brien v. O'Brien*, 66 N.Y.2d 576, 589, 489 N.E.2d 712, 719, 498 N.Y.S.2d 743, 750 (1985); *Blickstein v. Blickstein*, 99 A.D.2d 287, 472 N.Y.S.2d 110 (1984); *Corsel v. Corsel*, 133 A.D.2d 604, 604, 519 N.Y.S.2d 710, 711 (1987). The four New York Appellate Divisions (intermediate level courts of appeal) are divided as to whether marital fault can play a role in determining maintenance and the scope of its influence. Compare *Stevens v. Stevens*, 107 A.D.2d 987, 484 N.Y.S.2d 708 (3d Dep't 1985), and *Nolan v. Nolan*, 107 A.D.2d 190, 486 N.Y.S.2d 415 (3d Dep't 1985) (egregious marital fault can be taken into account in setting maintenance awards), with *Wilson v. Wilson*, 101 A.D.2d 536, 476 N.Y.S.2d 120 (1st Dep't 1984), *appeal denied*, 67 N.Y.2d 667, 476 N.E.2d 1006, 487 N.Y.S.2d 1027 (1985), and *Maloney v. Maloney*, 114 A.D.2d 440, 494 N.Y.S.2d 356 (2d Dep't 1985) (generally excluding marital fault from consideration in fashioning maintenance awards).

67. In *Blickstein v. Blickstein*, 99 A.D.2d 287, 472 N.Y.S.2d 110 (1984), the seminal New York case defining the role of marital fault in equitable distribution, the court referred to a New Jersey case, *D'Arc v. D'Arc*, 164 N.J. Super. 226, 395 A.2d 1270 (1978), *aff'd*, 175 N.J. Super. 598, 421 A.2d 602 (1980), *cert. denied*, 451 U.S. 971 (1981), as an example of the degree of marital misconduct that could influence equitable distribution. The husband in *D'Arc* had offered \$50,000 for the murder of his wife during the pendency of divorce proceedings.

68. See *infra* note 88-103 and accompanying text.

of fault, health of the spouses is a statutorily mandated and appropriate factor to consider in determining equitable distribution of marital property and setting maintenance.⁶⁹ An ill spouse might, for example, have a claim to receive a greater award of maintenance or property because he is especially needy.

However, in the hypothetical case of *Rodgers v. Rodgers*, Larry, the spouse suspected of HIV infection, denies it. He has *not* made a claim to a greater share of the family's resources because of ill health. Should he prove later to be HIV-infected, Larry has waived any claim of entitlement to a larger share of the equitable distribution or maintenance on health grounds.

C. Custody

Sharon's strongest argument for a compulsory blood test is that Larry's possible HIV infection is relevant to determination of Rachel's custody. Courts have generally deemed liberal discovery to be essential in custody disputes "for the overriding concern of the court is the best interests of the children and each [parent's] physical and mental condition is . . . subject to challenge."⁷⁰ There is a social expectation that when a court must decide the welfare of a child, parental expectations of privacy are largely deemed waived. Hence, it is standard operating procedure for custody litigants to undergo extensive examination by psychiatrists or other mental health professionals to aid the court in making the necessary determinations.

Assume for the moment that Larry is seropositive. Sharon might use that finding as the basis of an argument that Larry should have no custody rights.⁷¹ Alternatively, she could argue that her custody rights should be greater than Larry's because, since he is HIV-infected, she is the "more fit" parent.

Consideration of Sharon's argument that Larry's positive HIV test should terminate his custody rights altogether must begin from the premise that the parent-child relationship is constitutionally protected. It cannot be

69. N.Y. DOM. REL. LAW § 236(5)(d)(1) (McKinney's 1988).

70. *Burgel v. Burgel*, 141 A.D.2d 215, 533 N.Y.S.2d 735 (1988) (dissenting opinion). In *Burgel* a sharply divided Appellate Division affirmed a trial court order in a custody dispute that, pursuant to the husband's motion under section 3121, compelled the wife to have a physician cut several strands of her hair to perform a radioimmunoassay test. The wife admitted that she used cocaine in the past but claimed to have ceased using it a number of months before the order was entered. The purpose of the radioimmunoassay test is to confirm whether the wife *continued* to use cocaine. In *Rodgers*, in contrast, there is no evidence of past or continuing high-risk activity by Larry.

71. The question of what custody arrangements might be in the best interests of children of HIV-infected parents will be discussed as part of the Billings case study. See *infra* notes 104-11 and accompanying text.

severed without a showing of a compelling interest, usually the welfare of the child.⁷²

The "compelling interest" showing is almost impossible to make in the context of a divorce, absent abuse or neglect of the child or some other showing of serious parental unfitness.⁷³ Significant public policy reasons support the constitutional protection provided to the continuation of the parent-child relationship after divorce. Children generally adjust better to the trauma of a divorce if they continue meaningful relationships with both parents after it; they are also more likely to receive adequate and regular support from parents in those circumstances.⁷⁴

The question then is whether some compelling state interest could support complete termination of the parent-child relationship if Larry is seropositive. Sharon could conceivably assert two such interests, first, the need to protect Rachel from the risk of HIV infection, and, second, the need to punish Larry for the manner in which he became HIV-infected.

Larry, however, presents no danger to Rachel's health. The risk that Larry will transmit the HIV virus to Rachel through normal parent-child interaction is so small as to be nonexistent. There is not a single reported case of HIV being transmitted absent high-risk behavior or blood transfusion. Numerous studies of AIDS victims in a family setting have not produced a single case of AIDS being transmitted through day-to-day casual contact.⁷⁵ There is also no evidence Larry has engaged in high-risk behavior of any kind with Rachel.

In the past, findings of marital fault heavily influenced child custody decisions.⁷⁶ The trend of the recent decisions is in the other direction. The reason is that findings of marital fault generally evaluate the quality of the relationship between parents, not the primary question in a custody dispute, the relationship of parent to child.

Marital fault is thus generally relevant to a child custody determination only to the extent it is directly related to the capacity to parent.⁷⁷ Discreet

72. See, e.g., *Lehr v. Robertson*, 463 U.S. 248, 261 (1983) (noting that an unwed father's interest in contact with his child is protected by the due process clause); *Stanley v. Illinois*, 405 U.S. 645, 658 (1972) (holding that an unwed father is constitutionally entitled to hearing on fitness as a parent before a child is removed from his care). See generally *Developments in the Law: The Constitution and the Family*, 93 HARV. L. REV. 1156, 1328 (1980) (discussing constitutional protection for family relationships).

73. E.g., *Katz v. Katz*, 97 A.D.2d 398, 467 N.Y.S.2d 223 (1983) (father who abused wife in child's presence cannot be denied all visitation with the child); *Verdino v. Verdino*, 530 N.Y.S.2d 444 (Fam. Ct. 1988) (father's criminal background, recent three-year prison sentence, and likely deportation insufficient to terminate all visitation rights).

74. See Schepard, *Cooperative Custody*, *supra* note 11, at 703-20.

75. See sources cited *supra* notes 29-30 and accompanying text.

76. Schepard, *Cooperative Custody*, *supra* note 11, at 695, 723-24 and sources cited therein.

77. See *id.* at 723-24.

adultery, for example, does not disqualify a spouse as a parent.⁷⁸ Nor does discreet homosexuality.⁷⁹ On the current record, Larry's HIV infection does not even conclusively establish his marital fault. Even if it did, that fault is not related to his parenting of Rachel.

Sharon thus has no serious argument that Larry's custody rights should be terminated entirely because he is HIV infected. She can, however, make a more subtle and substantial claim. She might contend that she is "more fit" than Larry to exercise primary physical and legal custody of Rachel because Larry is HIV infected.⁸⁰ Larry's relationship to Rachel should, Sharon will contend, thus be limited to circumscribed visitation rights.

Larry's health is, in a general sense, a relevant factor to be considered in determining Rachel's custody.⁸¹ But the factor must be in context. Many parents are not the picture of physical and mental fitness. Less than perfect health not posing a serious danger to the welfare of a child does not disqualify a parent from custody rights. The issue for decision is not which parent is healthier, but how the handicap affects the parent's ability to perform his parental functions in the total context of the relationship between parent and child.⁸²

There is no present evidence or allegation that Larry is physically or mentally incapacitated in any way that affects his ability to parent Rachel. As far as the current record reveals, he is a healthy, functioning father. Mental incapacities associated with the final stages of full-blown AIDS generally do not appear before the symptoms of the disease itself. There is no evidence that HIV testing "would be useful in predicting the onset of functional impairment in persons who remain otherwise healthy."⁸³

78. See *Pawelski v. Buchholtz*, 91 A.D.2d 1200, 459 N.Y.S.2d 190 (1983) ("A parent's infidelity or sexual indiscretions should be a consideration in a custody dispute only if it can be shown that such factor may adversely affect the child's welfare"); *Matter of Rodolfo CC v. Susan CC*, 37 A.D.2d 657, 657, 322 N.Y.S.2d 388, 390 (1971) (proof that men on occasion remained overnight with the mother in the presence of her son did not constitute such "gross moral turpitude as would render her unfit for custody particularly since there is no showing that such conduct was actually affecting Robert's upbringing").

79. *Anonymous v. Anonymous*, 120 A.D.2d 983, 983-84, 503 N.Y.S.2d 466, 467 (1986) (lesbian not less fit for custody than other parent "[i]n the absence of proof that the child has been adversely affected by [mother's] life style"); *Guinan v. Guinan*, 102 A.D.2d 963, 477 N.Y.S.2d 830 (1984) (same).

80. See *Salk v. Salk*, 89 Misc. 2d 883, 393 N.Y.S.2d 841 (Sup. Ct. 1975) (illustrating breadth of factors to be taken into account in "comparative fitness" inquiry).

81. *Rosenblitt v. Rosenblitt*, 107 A.D.2d 292, 294, 486 N.Y.S.2d 741, 743 (1985).

82. See *Hatz v. Hatz*, 116 Misc. 2d 490, 455 N.Y.S.2d 535 (Fam. Ct. 1982), *aff'd*, 97 A.D.2d 629, 468 N.Y.S.2d 943 (1983) (court denies father's request to change custody of son after auto accident which left custodial mother a paraplegic). The landmark case nationally on the custody rights of handicapped parents in the California Supreme Court's decision in *In re Marriage of Carney*, 24 Cal. 3d 725, 598 P.2d 36, 57 Cal. Rptr. 383 (1979).

83. N.Y. Times, March 19, 1988, at 32, col. 5 (quoting summary statement of conference of World Health Organization's special AIDS program); N.Y. Times, June 17, 1988, at B4, cols. 1-2 (quoting results of a two-year study conducted under the auspices of the National Institute of Allergy and Infectious Disease comparing different groups of people infected with the AIDS virus and a control group).

Sharon will nonetheless argue that Larry's HIV infection is a different kind of parental "handicap" than all others. Larry is likely to die in the foreseeable future, and his physical condition will degenerate before then. The court, Sharon will contend, should heavily weigh the potential traumatic impact on Rachel of being placed in the primary custody of a parent facing deterioration and death.

Sharon's argument has powerful surface appeal. A parent's death is a highly salient event in the emotional life of a child, although not necessarily causally related to long-term serious depression or other psychopathology.⁸⁴ The death of a parent suffering from AIDS, a disease which carries a special social stigma, may be more traumatic for a child than death from other causes.⁸⁵

In further support of the motion to compel an HIV blood test, Sharon would, no doubt, add that Larry's unwillingness to voluntarily take the test and assure the court about his health indicates lack of concern for Rachel. For example, there is some suggestion in the research literature that therapeutic intervention focused on encouraging the child to cry over and appropriately mourn the dead parent in the immediate period after bereavement reduces resulting behavioral and emotional problems.⁸⁶ Sharon would argue that Larry's unwillingness to take a blood test and disclose if he is HIV-infected (if, in fact, he is) deprives Sharon and Rachel of the capacity to prepare for and understand his death. Thus, his very failure to agree to the HIV test is further indication of his unfitness for primary custody.

Larry's HIV blood test result thus is relevant to a future court determination of Rachel's custody. Nonetheless, Sharon's motion for a compulsory test should still be denied because it is untimely. The public policies of encouraging voluntary HIV testing and postdivorce spousal cooperation simply outweigh the importance of the information to be gained at present. Larry is not currently incapacitated in any way. Nor is there any proof that he engages in high-risk behavior making him more likely to be HIV-infected than any member of the general population. If

84. See Ragan & McGlashan, *Childhood Parental Death and Adult Psychopathology*, 143 AM. J. PSYCHIATRY 153 (1986); Van Eerdewegh, Clayton & Van Eerdewegh, *The Bereaved Child: Variables Influencing Early Psychopathology*, 147 BRIT. J. PSYCHIATRY 188 (1985). The most critical factor in a child's adjustment to a parent's death is the child's supportive relationship with the functioning, surviving parent. Breier, *Early Parental Loss and Development of Adult Psychopathology*, 45 ARCH. GEN. PSYCHIATRY 987 (1988).

85. New York City school system personnel who designed and operate a model program for counseling children about AIDS made the following comments about the impact of a child's knowing someone who is dying of AIDS. "Children often experience fear, confusion and denial when people they know die from AIDS virus, and the stigma that is attached to the disease makes the death more difficult to accept. . . ."; "AIDS-related deaths are serious, ugly, long, . . . [f]or a child to see this, the problems are monumental." N.Y. Times, July 16, 1988, at B2, cols. 1-2, 3.

86. See Black & Urbanowitz, *Family Intervention with Bereaved Children*, 28 J. CHILD PSYCHOLOGY & PSYCHIATRY 467 (1987).

Larry is HIV-infected, there is simply no way of predicting how long it may be before he manifests the clinical symptoms of AIDS or ARC.

At present, the court does not need Larry's HIV test results to determine Rachel's custody, and should do so based on present information. Should Larry's physical or mental condition change as he develops symptoms of AIDS or ARC, a blood test could be ordered and the court's initial custody award modified.⁸⁷ In that event, a protective order should issue barring any disclosure by Sharon or her lawyer of the blood test results to anyone. Furthermore, in the future custody determination, the court should take Larry's earlier unwillingness to agree to an HIV test voluntarily into account as evidence that he is less fit to be the primary custodian than Sharon.

VI. The Billings Family Case Study

Family Composition:	John Billings	Age 38
	Mary Billings	Age 35
	Son Robert	Age 13
	Daughter Jill	Age 10
	Son Tom	Age 6

John Billings was born and raised in New York City. His father, a school teacher, died when John was twenty-four. His mother, still living, is a housewife. John was particularly close to his father, who stressed academic performance and altruistic ideas, which John adopted.

While in graduate school, John met and married Mary after a brief courtship. He was twenty-three and already developing a reputation as a brilliant researcher. His major was biology, with a special interest in virology.

Upon completion of his doctorate, John worked for the National Institutes of Health in Bethesda, Maryland, where the family lived when Robert was born. They moved to New York when John was offered a research position at Columbia University, where he currently works. He is presently a tenured professor of biology and director of the research lab facility at the College of Physicians and Surgeons. The other children were born in New York.

Mary Billings, raised in New Jersey, came to New York to study fashion design. She is one of three children. Her father was a mid-level executive for Lipton Tea, and her mother worked in graphic design.

Mary met John when she was twenty, and on the rebound from a three-year relationship that started in high school. She found work

87. Cf. *Friederwitzer v. Friederwitzer*, 55 N.Y.2d 89, 432 N.E.2d 765, 447 N.Y.S.2d 893 (1982) (standard for custody modification is "best interests of the child" whether initial arrangement is based on parental agreement or court order).

designing children's clothes when they married and worked for two manufacturers over the years. With each child's birth, she stopped working for about eight months, but continued part-time free lance work from home for several years. She has been working full time since Tom was four.

John and Mary's marriage was stable over several years, although children and dual careers caused some strain. John was, at times, pressed to submit research grant requests and publish. He accomplished these tasks quite successfully, in spite of long work hours and extensive travel to conferences. Mary's work, because of its seasonal deadlines, was punctuated with crises. She coped by locking herself in her work room until the deadline was met, depending upon hired help and John during these periods.

Approximately two years ago, while doing research work on the HIV virus, John stumbled, knocked into some vials of concentrated virus, gashed his hand on one and contaminated himself. After the accident, he declined to have sexual intercourse with Mary for fear of infecting her. As soon as John tested seropositive, he told Mary about his infection.

Initially, Mary expressed horror and concern for John's health, wanting to know everything about the virus. She began, however, to become obsessively concerned with the risk of transmission. Mary began to put the dishes through two cycles of the dish washer, as well as to segregate John's eating utensils. She boiled the sheets, and fastidiously emptied the wastepaper baskets, worrying if John discarded a used tissue. Mary took "precautions" when John involved himself with the children as usual, including washing them, sharing utensils. She became intensely agitated when John gave a bite of an apple to little Tom.

Over the next several months, Mary stopped holding hands or having any casual physical contact with John. After John informed her of the test results, Mary refused to have sex with him, and finally asked him to sleep in the guest bedroom. She has tested seronegative, although she constantly worries that she will become infected.

When Mary admits her responses are exaggerated, she states that she cannot control her reactions. John suggested counseling, which they attempted but discontinued because Mary feared she would end up sleeping with John and getting AIDS.

John has begun to manifest some of the symptoms of ARC. He is unsure how long he can continue to work. His failing health increases Mary's distress. John's employer wants him to stay on the job as long as possible. His colleagues are supportive of him.

At Mary's insistence, John reluctantly agreed to divorce. They have not, however, agreed on a distribution of their marital property, maintenance, child support, or custody arrangements.

VII. AIDS and Divorce-Related Economic Decisions

Mary and John's divorce is quite different than Sharon and Larry's. Mary has no basis for any suspicion that John's HIV infection results from an act of marital fault. John has also abstained from high-risk behavior and been candid with Mary in disclosing his HIV infection.

John and Mary's divorce sharply raises the question of how the legal system should manage the effects of their upcoming dissolution. (The question whether it should permit Mary to divorce John over John's objection will be discussed subsequently.) Absent moral blame, the divorce process should treat John's HIV infection as any other fatal, debilitating disease. The problem, however, is that the courts do not have a consistent legislative framework or philosophy to guide them in addressing the economic issues that accompany this problem.

New York's Equitable Distribution Law is a comprehensive, integrated approach to the problems of economic distributions at divorce with three components: property division, maintenance and child support.

The Equitable Distribution Law requires the court to consider thirteen factors in distributing marital property. They include "the probable future financial circumstances of each party,"⁸⁸ "any award of maintenance,"⁸⁹ and, most significantly for present purposes, "the age and health of both parties."⁹⁰ The EDL also requires the court to consider similar factors in setting maintenance.⁹¹ A shorter group of factors (specifically excluding parental misconduct) determines child support payments, including "where practical and relevant, the standard of living the child would have enjoyed had the marriage not been dissolved."⁹²

Thus some, but not all, of the factors determining property distribution, maintenance, and child support awards require the court to consider the "health" and "needs" of the parents and the children. Others require consideration of their respective contributions to the marriage and raising of children. Still others mandate the court to maintain the pre-separation standard of living. The statute does not set a priority on any one factor, but requires consideration of all. The breadth and interrelationship of the factors to be considered allows the courts great discretion to make economic determinations on a case-by-case basis.⁹³ Mary and John and their

88. N.Y. DOM. REL. LAW § 236(B)(5)(d)(8) (McKinney 1988).

89. *Id.* § 236(B)(5)(d)(5) (McKinney 1988).

90. *Id.* § 236(B)(5)(d)(2) (McKinney 1988).

91. *Id.* § 236(B)(6)(1)-(11) (McKinney 1988).

92. *Id.* § 236(B)(7)(3) (McKinney 1988).

93. The breadth of discretion given judges to allocate the parties' assets and assess spousal and child support under American (and British) law is far greater than in the Scandinavian countries or those of continental Europe. As recently stated by Professor Glendon: "[T]he chief effect of these large grants of discretion is to deprive the spouses and their legal representatives of any clear principles that could serve as the backdrop for negotiations." M. GLENDON, *supra* note 3, at 86.

lawyers thus have very little guidance about how a court would ultimately make distributional decisions if they cannot agree on a settlement.

Let's make the following unlikely assumptions about the Billings' family finances for purposes of exploring what impact John's ARC might have on the divorce distribution. Assume that John does not have medical insurance coverage or life insurance.⁹⁴ The family's total resources are, however, too great for John to qualify for Medicaid.⁹⁵ Finally, assume, as is likely, that the Billings' resources are finite and all members of the family will be unable to maintain their standard of living after the divorce.

There are, in essence, three possible, but inconsistent, theories that could govern the division of the family's assets:

1. *Pauperize John*—One might argue that most family wealth should be distributed to Mary and the children, since John is likely to die in the relatively near future. Making John a virtual pauper will shift the considerable costs of his medical care⁹⁶ to society by making him eligible for Medicaid. An unequal distribution of wealth to Mary and the children can be viewed as compensation for the irreparable loss of John's future income stream.

2. *Distribute more resources to John*—Alternatively, it could be argued that John should receive a disproportionate share of the family wealth at divorce because he needs extra resources to cover his medical costs and to prevent the indignity of pauperization by disease.

3. *Neutrality*—Finally, a court could divide the family wealth without regard to whether John is HIV-infected on the theory that the decree represents a distribution of his vested property rights. His special future health needs can be taken into account in setting maintenance payments.⁹⁷

94. There is a substantial debate on the impact of AIDS on the life insurance industry. The industry estimates that by the mid-1990s AIDS-related deaths could constitute 10 percent of the life insurance industry's total claims. AMERICAN COUNCIL OF LIFE INS., AIDS AND LIFE INSURANCE 4 (1987).

95. People diagnosed as having AIDS are presumed to be disabled under the Supplemental Security Income program and thus become eligible for Medicaid. Nationally, about 40 percent of AIDS patients qualify for Medicaid, with the proportion rising to 65 or 70 percent in New York City. The Supplemental Security Income program "provides benefits to disabled persons with low incomes and few or no assets. In 36 states (where 90 percent of the reported AIDS cases have occurred) those eligible for Supplemental Security Income are automatically eligible for Medicaid. . . . Patients with AIDS not qualifying for Supplemental Security Income may still become eligible for Medicaid as medically needy individuals. . . ." Roper, *From the Health Care Financing Administration*, 258 J. A.M.A. 3489 (1987).

96. Estimates of hospital costs over the lifetime of a patient with AIDS range from \$24,517 to \$147,000. Iglehart, *Health Policy Report: Financing the Struggle Against AIDS*, 317 NEW ENG. J. MED. 180, 182 (1987). A recent study by a government economist, which includes the cost of AZT, an AIDS treatment drug, estimates lifetime treatment costs at \$69,000. N.Y. Times, May 25, 1988, at B17, col. 7.

97. See *Antis v. Antis*, 108 A.D.2d 889, 485 N.Y.S.2d 770, 771 (1985) (trial court maintenance award to wife raised in light of her mental illness and disfigurement due to burns); *Rodgers v. Rodgers*, 98 A.D.2d 386, 389, 470 N.Y.S.2d 401, 404 (1983) (increased mainte-

None of these approaches is fully satisfactory. Each, however, has support in the language of and theory behind the EDL's statutory factors.

The pauperization approach is grounded in sad economic reality. It recognizes that the Billings family will be losing a breadwinner and attempts to preserve as much of the family assets for Mary and the children as possible. It is, however, a problematic attempt to shift the burden of John's medical care from the family to the state.⁹⁸ The authorities regulating eligibility for Medicaid may view the divorce distribution as a sham and challenge it.⁹⁹ Furthermore, John's pauperization deprives him of property to which he is entitled. It adds economic indignity to the indignity of a fatal disease.

Distributing a larger share of the family resources to John reinforces private responsibility for financing John's health care and recognizes his need to continue to live a comfortable life while ill. However, this theory depletes resources available to Mary and the children for John's benefit and John is likely to die in the very near future.

The neutrality approach seems fairest. It neither punishes nor provides extra compensation for John. The special needs of any family member is recognized through maintenance or child support payments, which look

nance award to wife in poor health to assist her in maintaining standard of living and to make health insurance payments).

98. The legal and public policy issues are very similar to those posed by shifts of assets between elderly spouses or between parents and children to qualify for Medicare. "Medicaid eligibility rules permit knowledgeable individuals to transfer or shelter property from Medicaid resource limitations in a manner reminiscent of income tax avoidance. Less savvy applicants are denied eligibility and have to liquidate their assets and spend down to Medicaid limits at great inconvenience and financial loss to their families. Whether assets are transferred or liquidated, they are lost as a future source of revenue to the Medicaid program through estate recoveries." DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, *MEDICAID ESTATE RECOVERIES* ii (1988). Divorces—often for no other purpose—are one of many devices used by lawyers to impoverish an ill spouse and preserve income and assets for the family by shifting long-term care expenses to Medicaid. *Id.* at v. These realities provide an economic incentive for John and Mary to divorce even if neither wanted to do so. One might question the moral basis of government policy which requires spouses to choose between financing humane long-term medical care and family stability. *Cf.* Callahan, *What Do Children Owe Elderly Parents?* 15 *HASTINGS CENTER REP.* 32, 36 (1985) (suggesting that from point of view of promoting family unity between parents and children, government should provide medical care for the elderly).

99. Congress recently amended and broadened the rules regulating asset transfer for Medicaid eligibility. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 303(b) (July 1, 1988). The new legislation applies to transfer of assets on or after July 1, 1988. Under it, states must deny Medicaid eligibility to any institutionalized person who has transferred any asset, including a residence, for less than fair market value within the thirty months prior to the application for Medicaid. Exceptions to this general rule include the transfer of a home to a spouse or the transfer of any asset exclusively for a purpose other than to qualify for medical assistance. See J. REGAN, *TAX, ESTATE AND FINANCIAL PLANNING FOR THE ELDERLY* § 10.05[6], at 10-23-25 (1988) for a summary and explanation of the differences between the old and new rules on asset transfers for Medicaid eligibility.

to the future and can be modified.¹⁰⁰ However, the neutrality approach still leaves less resources available for Mary and the children.

The difficulty of choosing between these competing approaches to some extent highlights the virtue of the flexibility provided to the courts by EDL. Decisions about which approach, or combination thereof, to apply are made on a case-by-case basis. The assumption that John will not have health or life insurance is, for example, unlikely.¹⁰¹ If he does, the burden of his care and the divorce on the family resources will be far easier to cope with.

Furthermore, the longer John continues to work and provide income, the less the economic impact of the divorce on the family unit.¹⁰² This reasoning emphasizes the importance of prohibitions against employment discrimination against AIDS sufferers.¹⁰³

VIII. AIDS, Custody and Visitation

Assume now that John and Mary cannot agree on what the custody ar-

100. See N.Y. DOM. REL. LAW § 236(B)(9)(b) (McKinney 1988) (court can modify prior order of maintenance "upon a showing of the recipient's inability to be self-supporting or a substantial change in circumstance, including financial hardship"); *Brescia v. Fitts*, 56 N.Y.2d 132, 436 N.E.2d 518, 451 N.Y.S.2d 68 (1982) (standard for modification is "change of circumstances" where child's right to receive adequate support is at issue); *Archer v. Archer*, 531 N.Y.S.2d 69, 70 (App. Div. 1988) (wife's maintenance payments increased because health has deteriorated to point where she can no longer work and needs twenty-four-hour assistance and because husband's resources have substantially increased).

101. Empire Blue Cross and Blue Shield (New York City) does no medical underwriting of its individual applicants for basic insurance coverage. Acceptance of individual new applicants is not contingent upon their medical history or present medical condition. Even major medical insurance is available from Empire Blue Cross and Blue Shield without medical underwriting once a year, during an open enrollment period. The individual contracts, however, exclude payment of benefits for preexisting conditions during the first eleven months of coverage. Ehrlich, *Paying for AIDS Care—The Insurance Issues* (unpublished address by Associate General Counsel of Empire Blue Cross-Blue Shield to Forum for Health Care Planning, July 25, 1987) (Schepard file).

Other Blue Cross/Blue Shield Groups as well as private carriers have varying policies as to medical underwriting, availability of coverage, and exclusions of pre-existing conditions.

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. No. 99-509, 100 Stat. 1889 (1986), requires continuation of an employee's group health insurance plan (if requested and with the employee or dependent paying the premium therefor) for eighteen months for terminated employees and for thirty-six months for (1) a spouse and dependents of deceased employees and (2) a divorced or legally separated spouse and dependents of covered employee. COBRA does not apply, however, to employers who have less than twenty employees, to governmental plans, or to self-insured plans.

102. Improved medical treatment for AIDS victims has increased their capacity for work after diagnosis significantly. The Bank of America, for example, reports that almost 100 percent of employees with AIDS return to work after diagnosis, up from 20 percent to 30 percent four or five years ago. Ricklefs, *Living With AIDS*, Wall St. J., Sept. 28, 1988, at 1, col. 1.

103. AIDS infection is considered a "handicap" under federal, state, and local law, making employment discrimination based thereon generally unlawful. See Parmet, *AIDS and the Limits of Discrimination Law*, 15 L. MED. & HEALTH CARE 61 (1987); Leonard, *AIDS and Employment Law Revisited*, 14 HOFSTRA L. REV. 11 (1985).

rangements should be for the Billings children after divorce. The issue then becomes what custody arrangement the courts should impose, and the lawyers should encourage, as in the best interests of John, Mary and their children.

It is possible to make finely calibrated distinctions between types of postdivorce parental custody arrangements. However, the essential problem all deal with is allocation of two types of rights and responsibilities.

The first, roughly encapsulated in the term "physical custody," is parental entitlement to a child's physical presence. Visitation is, in essence, a form of physical custody. In contrast, "legal" custody is the power to make key decisions for the child—where he lives, goes to school, gets medical care, etc.¹⁰⁴ A continuum of allocations is possible, ranging from "sole" (one parent has all physical and legal custody rights) to "joint" (parents share both forms of custody rights approximately equally).¹⁰⁵

Unlike thirty-five other states,¹⁰⁶ New York has no statute guiding the discretion of the courts as to when joint custody is appropriate, or what factors to consider in making custody determinations. Courts are guided solely by the indeterminate "best interests of the child" standard.¹⁰⁷ New York courts will generally not award joint custody if one of the parents disagrees with the concept.¹⁰⁸

This article has already concluded that the same continuum of possible custody arrangements should exist for the Billings family as in all other divorces. In other words, John's custody rights should not be terminated solely because of his infection.¹⁰⁹

The question remains as to what kind of custody arrangement will serve the best interests of the Billings children. The empirical evidence is overwhelming that a child's regular and meaningful relationship with both parents following divorce is the goal courts should aim at to alleviate as much of the child's suffering as possible.¹¹⁰

The concern for a meaningful postdivorce relationship is magnified when one of the divorcing parents is HIV-infected. The Billings children

104. See Schepard, *Cooperative Custody*, *supra* note 11, at 693–95, 701–02 and sources cited therein.

105. See *id.* at 693–95 and 701–03 and sources cited therein.

106. Freed & Walker, *supra* note 5, at 520 (Table IX).

107. N.Y. DOM. REL. LAW § 240(1) (McKinney 1988). For discussions of the effects of the indeterminacy of the "best interests" standard, see Schepard, *Cooperative Custody*, *supra* note 11, at 721–22 (arguing that absence of standards to guide judicial discretion increases the risk of arbitrariness in custody determinations and discourages joint custody awards); Mnookin, *Child Custody Adjudication: Judicial Function in the Face of Indeterminacy*, 39 LAW & CONTEMP. PROBS. 226 (1975).

108. *Braiman v. Braiman*, 44 N.Y.2d 584, 378 N.E.2d 1019, 407 N.Y.S.2d 449 (1978). For a critique of *Braiman* and its view of the needs of the children of divorce, see Schepard, *Cooperative Custody*, *supra* note 11, at 714–16.

109. See *supra* notes 72–79 and accompanying text.

110. The evidence is summarized in Schepard, *Cooperative Custody*, *supra* note 11, at 703–09.

need to understand that the cause of their father's likely death is a disease that carries a social stigma, even if "innocently" acquired. They need to have access to John (and appropriate counseling) to come to terms with these potentially monumental psychic wounds.¹¹¹ Artificially restricting John's relationship with his children will deprive them all of the opportunity to adjust to these incredibly painful events in their lives, and grow accordingly.

A major goal of any custody arrangement for the Billings children should thus be to attempt to preserve as much of a relationship between the children and John as possible.¹¹² The court should evaluate John's capacities to perform parental functions exactly as it would for any other parent afflicted with a disease or handicapping condition. How much physical and legal custody John should have, if he and Mary cannot agree, should be decided in the identical fact-sensitive manner that custody rights are allocated in non-AIDS divorce-related custody disputes.

A court may, however, have to make hard choices. Given the psychological trauma and instability associated with a child's experience of parental debilitation and death, and all other factors being relatively equal, Mary seems to be the preferred legal custodian for the children. She will remain the anchor in their lives after John is gone, even if she presently is acting somewhat irrationally. As a condition of being awarded legal custody, Mary should ensure that John has as much physical custody rights as his medical condition permits and is fully and completely consulted on all decisions concerning the children. Mary should also be prohibited from moving the children away so that John's access to them will be made more difficult. If Mary is unwilling to give John extremely generous physical custody and is unwilling to promote his continuing relationship with the children, her fitness to serve as the children's legal custodian should be reconsidered. In effect, she would be depriving her children of the right to come to terms with their father's death. The current record, however, contains no indication of such behavior.

IX. Procedure in AIDS Divorce Cases

A. *The Special Responsibilities of Counsel*

The human and public interests at stake in an AIDS-related divorce are highly significant. John and Mary's lawyers and Sharon and Larry's lawyers thus should bear a special responsibility to reduce acrimony, facilitate communication and planning for the future, and protect the welfare of the children.

111. See *supra* notes 85-86 and accompanying text.

112. Schepard, *Cooperative Custody*, *supra* note 11, at 703-35.

1. SHOULD THE BILLINGS DIVORCE?

Above all, the lawyers need to engage in especially effective counseling and moral persuasion to mute and temper their clients' more extreme directions and emotions. Counsel should discourage vindictiveness and hysteria. They should recognize the fear that AIDS inspires, but help their clients place it in a realistic context. The need to accomplish these goals comes into sharp focus when the question of whether Mary Billings should be allowed to divorce John, over his objections, is considered.

A serious argument can be made that a court should not allow Mary to divorce John and that, in any event, Mary's lawyer should discourage her from pursuing that course of action. We have assumed up until now that John would agree to Mary's request for a divorce. As previously discussed, his consent would be essential under New York law. Otherwise, Mary would have to prove John's marital fault, which she could not do.¹¹³

Assume, however, we are in a unilateral no-fault state and Mary is entitled to a divorce on "irreconcilable differences," or some other ground, over John's objection. A question still remains whether a court should allow Mary a divorce because of the exceptional circumstances of a spouse dying of an innocently acquired fatal disease.

As Mary Anne Glendon has recently reminded us, no-fault divorce is really a misnomer. The original purpose of eliminating or modifying fault grounds was not to allow divorce on demand, but to allow a court to consider the entire history and fabric of the marriage in making a decision to allow dissolution of the family unit.¹¹⁴

The divorce laws of England, West Germany and France allow one spouse to divorce an unwilling, but legally guiltless, partner after a substantial waiting period. They also, however, keep open the possibility that the court may deny the divorce petition in cases of "exceptional hardship." The "exceptional hardship" discretionary exception to the right to divorce is, however, rarely applied.¹¹⁵

If such an exception were applied, or if the court considered the "total context" of the marriage relationship under a no-fault law, and John resisted Mary's desire to divorce, a strong argument could be made that the court should deny it. Mary's desire to end her relationship with John will eventually be satisfied by the passage of time and the progression of his disease. The only good reason for Mary to divorce John (other than to qualify him for Medicaid) is to protect the family's financial resources for her own and the children's benefit. There seems to be very little risk, however, that John will deplete them deliberately. If the Billings remain married, the emotional dislocations accompanying divorce—and perhaps a custody trial—can be avoided. Furthermore, the symbolic importance

113. See *supra* text accompanying notes 37–38.

114. M. GLENDON, *supra* note 3, at 78–79.

115. *Id.* at 74.

of marriage "for richer or poorer, in sickness and in health" would be reinforced by the court's denial of Mary's divorce.¹¹⁶

Mary's lawyer has the responsibility of recognizing that her desire to divorce is largely motivated by irrational fear that John will transmit the HIV virus to her and the children. The lawyer needs to tactfully raise the subject with Mary to help her define the objectives of the lawyer's representation. A decision by Mary not to seek a divorce guided and informed by her lawyer's advice and counsel should be viewed as a significant professional achievement.

2. PLANNING FOR THE FUTURE

Assuming that a divorce will occur, lawyers for the Billings must also guide their clients toward successful planning for coping with the resulting economic and emotional problems. We know very little about how well lawyers are suited to this task. We do know that the role of mediator and facilitator of the interests of the Billings children is not an ethical imperative for divorce counsel. The lawyer's formal professional responsibility obligations require him to promote the wishes of the parent-client, not the needs of the child. Mary's lawyer may believe, for example, that he or she has to argue and negotiate for decreased custody rights for John if Mary so instructs.¹¹⁷

In any event, counsel must encourage realistic planning for the future. Health and medical insurance are areas of special concern, as is estate planning. Some kind of trust arrangement for the benefit of the children might be considered. John might also consider executing a durable power of attorney or a living will for future decisions concerning his health care.¹¹⁸ Above all, counsel should encourage the clients to keep open the spousal lines of communication.

3. THE NEED TO ENCOURAGE CLIENT CANDOR

Return to the Rodgers family case study and assume that Larry has told his lawyer that he is HIV-infected. He has not, however, told Sharon for fear of how she will react. What should Larry's lawyer do?

At a minimum, Larry's lawyer should counsel him to reveal his infection to Sharon voluntarily. "In general, a lawyer is not expected to give advice

116. Another alternative might be for Mary to ask for a legal separation from John without a divorce. Unfortunately, in New York, an action for legal separation requires a showing of marital fault. N.Y. DOM. REL. LAW § 200 (McKinney 1986).

117. See Schepard, *Cooperative Custody*, *supra* note 11, at 740-42 (discussing the role of the lawyer in promoting cooperative custody arrangements, and noting the absence of any ethical imperative to do so).

118. The problems involved in tax, estate, and health care planning for the Billings family's future are very similar to the complex problems involved in similar planning for the elderly. See generally, J. REGAN, *supra* note 99.

until asked by the client."¹¹⁹ The possibility that Larry's not telling Sharon may result in both a tort and a crime,¹²⁰ the grave danger Larry's conduct poses to Sharon's health, and the possibility that she may unknowingly spread the HIV virus to others certainly warrant an exception to the general rule of lawyer passivity.¹²¹

If, after counseling, Larry still refuses to reveal his infection to Sharon, his lawyer faces an ethical dilemma of the highest order, and potential liability,¹²² in deciding whether to reveal it to Sharon himself. Larry's infection is surely a protected client confidence under either the *Code of Professional Responsibility (CPR)*¹²³ or the *Model Rules of Professional Conduct (Model Rules)*.¹²⁴ Larry's lawyer might reason that if he reveals Larry's infection to Sharon, other HIV carriers may be discouraged from making the kind of candid client communication informed legal advice and representation require.¹²⁵ He might also worry about possible civil liability to Larry for breach of confidence.

On the other hand, under the *CPR* a lawyer may reveal "[t]he intention of his client to commit a crime and the information necessary to prevent the crime."¹²⁶ Under the different formulation of the exceptions to the confidentiality requirement of the *Model Rules*, a lawyer may reveal client confidences "to the extent that the lawyer reasonably believes necessary . . . to prevent the client from committing a criminal act that the lawyer believes is likely to result in imminent death or substantial bodily harm."¹²⁷

119. MODEL RULES OF PROFESSIONAL CONDUCT Rule 2.1 comment (1983). The *Code of Professional Responsibility* suggests a contrary rule. See MODEL CODE OF PROFESSIONAL RESPONSIBILITY EC 7-8 (1980), quoted *infra* note 121.

120. See *supra* notes 56-57 and accompanying text.

121. Cf. MODEL RULES OF PROFESSIONAL CONDUCT Rule 2.1 (1983) ("In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation"); MODEL CODE OF PROFESSIONAL RESPONSIBILITY EC 7-8 (1980) ("A lawyer should exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant considerations. A lawyer ought to initiate this decision-making process if the client does not do so.").

122. See *Tarasoff v. Regents*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (psychiatrist liable for failure to warn victim of patient's threat to kill her).

123. MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 4-101 (1980). The CPR governs lawyers' ethical obligations in New York, N.Y. JUD. LAW, APPENDIX, CODE OF PROF. RESP. (McKinney 1975), which has not adopted the Model Rules of Professional Conduct. See LAW. MAN. ON PROF. CONDUCT (ABA/BNA) No. 66 § 1:3 (July 20, 1988) (list of jurisdictions that have adopted the Model Rules).

124. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.6(a) (1983) ("A lawyer shall not reveal information relating to representation of a client unless the client consents after consultation.").

125. Cf. M. FREEDMAN, LAWYERS' ETHICS IN AN ADVERSARY SYSTEM 1-8 (1975) (arguing lawyer's duty of confidentiality precludes lawyers of defendant in a murder case from informing families of other murder victims where the victims' bodies are buried).

126. MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 4-101(C)(3) (1980).

127. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.6(b)(1) (1983). "There is little guidance as to how the lawyer is to exercise the discretion" given to him in such situations. M. FREEDMAN, *supra* note 125, at 6.

Neither the *CPR* nor the *Model Rules* require that Larry's lawyer reveal John's HIV infection to Sharon; both seem to recognize that the serious interests in preserving Sharon's health and life justify discretion to disclose.

How should Larry's lawyer exercise his discretion? In the facts of the Rodgers case study as initially presented, Sharon is fully aware of the possibility that Larry may be HIV-infected. Indeed, she herself has been tested for the HIV virus. Her interest in her health can be preserved by other means than the lawyer's disclosure.¹²⁸ There does not seem to be a compelling need for an exception to the general rule of client confidentiality to protect Sharon.

The ethical dilemma for Larry's lawyer is, however, far more severe if Sharon is not aware of the possibility that Larry is HIV-infected, and the lawyer is the only one from whom Sharon is likely to learn the information.¹²⁹ In this circumstance, Larry's lawyer will have to decide if the value he places on Sharon's life and health is greater than the social purposes behind the guarantees of client confidentiality.¹³⁰ Under these circumstances, the author believes Larry's lawyer should disclose Larry's HIV infection to Sharon. In any event, this subject seems worthy of further study and reflection by the bar.¹³¹

B. *Alternative Dispute Resolution*

128. See Freedman, *Lawyer-Client Confidences Under the A.B.A. Model Rules: Ethical Rules Without Ethical Reason*, 3 CRIM. JUST. ETHICS 3, 5 (1984).

129. Cf. S. BOK, *LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE* 146-64 (1978) (suggesting that a physician who knows his patient has syphilis should reveal the information to the physician's fiancée).

130. See M. Freedman, *supra* note 128, at 5 (arguing that a lawyer be required to disclose client confidences in the "extraordinarily unlikely circumstances in which a human life is at stake and only the lawyer's knowledge can save it" because these circumstances "pose only the most remote and insignificant threat" to the purpose of the rule of confidentiality).

131. The American Medical Association has recently resolved a similar dilemma in favor of protection of potential AIDS victims. Its House of Delegates adopted a policy statement requiring physicians to notify and counsel endangered third parties if persuasion of the patient fails and notified public health authorities take no action to protect the third party. The AMA resolution also calls for legislation immunizing physicians from liability for the action. The President of the AMA called the resolution a "landmark in the history of medical ethics." N.Y. Times, July 1, 1988, at A1, col. 1 & A11, col. 1.

One possibility might be for lawyers to adopt the approach of the recent New York AIDS testing legislation and require that clients give "informed consent" to representation in AIDS divorces. The New York legislation requires that before a patient is tested for HIV infection, he be made aware that the doctor may disclose a positive test result to a sexual contact of the patient directly, or a public health official who would do the disclosure, if the patient himself refused to do so after counseling. 1988 N.Y. LAWS § 2782, ch. 584 (McKinney). A lawyer who has given his client such warnings in advance of beginning the representation would certainly feel more justified in making the disclosure to Sharon than one who has not. On the other hand, the result of such preliminary warnings "would be to caution the client not to be completely candid with the attorney," thereby potentially making the lawyer's representation less effective in serving the client's interests. M. FREEDMAN, *supra* note 125, at 38.

There is great debate about the role of mediation in divorce and custody disputes.¹³² It is difficult to conceive of a dispute resolution process more likely to permanently damage the relationships between Mary and John Billings and their children than adversary litigation over property distribution and custody rights. If any case is ever appropriate for "mandatory" mediation to promote expeditious and out-of-court settlement, an AIDS-related divorce is it.¹³³

If mediation efforts fail, the court should make full use of all other procedures to facilitate its expeditious, informed decision making and settlement, including appointment of neutral custody experts¹³⁴ and financial appraisers.¹³⁵ The court should also consider appointing a lawyer to represent the Billings children.¹³⁶

X. Legislative Change

A. *An AIDS Advisory Committee*

Courts with AIDS-related cases on their divorce dockets have a special responsibility to become knowledgeable about the disease and familiar with available community resources. In addition, medical information

132. The author was a co-consultant with Professor Linda Silberman of New York University Law School for a study by the New York State Law Revision Commission, which led to a recommendation for a publicly financed mediation system for custody disputes in New York. Schepard & Silberman, *Recommendations of the Law Revision Commission to the 1985 Legislature: Relating to the Child Custody Decision-Making Process*, 19 COLUM. J.L. & SOC. PROBS. 105 (1985) (describing the advantages of mediation and alternative dispute resolution in child custody disputes). A symposium issue of the *Columbia Journal of Law and Social Problems* contains much valuable commentary on the Law Revision Commission proposal and the merits and demerits of mediation in general. Symposium, *Children, Divorce and the Legal System: The Direction for Reform*, 19 COLUM. J.L. & SOC. PROBS. 393 (1985).

133. See generally Schepard, *Cooperative Custody*, *supra* note 11, at 756-59, 766-70, 776-79 (describing a publicly financed mandatory mediation program as the "centerpiece of a cooperative custody system," and evaluating the projected benefits of such a system and the arguments against it).

134. *Kessler v. Kessler*, 10 N.Y.2d 445, 180 N.E.2d 402, 225 N.Y.S.2d 1 (1962), is the basic case in New York authorizing the appointment of neutral experts to facilitate custody determinations.

135. See *Zirinsky v. Zirinsky*, 138 Misc. 2d 775, 525 N.Y.S.2d 464 (N.Y. Sup. Ct. 1987), *aff'd*, 529 N.Y.S.2d 298 (N.Y. App. Div. 1988) (court can appoint independent appraiser despite absence of statutory authorization).

136. The classic article advocating that lawyers for children be appointed in custody disputes is Note, *Lawyering for the Child: Principles of Representation in Custody and Visitation Disputes Arising from Divorce*, 87 YALE L.J. 1126 (1978). See Schepard, *Cooperative Custody*, *supra* note 11, at 746-50, for a critique of the idea, arguing that the different expectations of the role of lawyer for the child are inherently conflicting. The author has come to believe that if mediation fails, appointing a lawyer to represent the Billings children is probably better than not doing so. Mary's fear of contracting AIDS may confuse her thinking about the welfare of her family. John's illness and impending death may also cloud his vision of what is best for the children. The children should have an advocate who develops the available evidence about the effect on children of witnessing a parent's debilitation and death and who urges settlement.

about AIDS and its consequences for the family is constantly evolving. The court system needs an unbiased and readily available source of information and education about the disease, and a forum for developing recommendations for needed administrative or legislative change.

The needs can be satisfied by the legislature's establishing a medical-legal interdisciplinary advisory committee to provide the court system with current and knowledgeable advice about AIDS and how courts can cope with it. The scope of the advisory committee's work could include all AIDS-related cases on the docket of courts, not just divorces.

B. An Agenda for Legislative Change

AIDS-related divorces simply magnify the dilemmas caused in all cases by a divorce system whose substance and procedure emphasizes findings of fault. The problem is that marital fault is both too narrow and too broad a concept to deal with the issues such a divorce raises. The important questions are not whether an AIDS-infected spouse committed adultery or his spouse constructively abandoned him. Rather they are how did the spouse become HIV-infected, did the spouse act responsibly after learning of his or her infection, and how can the state best help the family unit cope with the consequences of impending divorce, deterioration and death.

We thus need to return to the original premises of misnamed no-fault divorce laws to cope with AIDS divorces—and indeed all divorces—to the best of our ability. Fault is a factor to take into account, but should not be the engine that drives divorce law and procedure.

To the extent that the problems of an AIDS-related divorce are simply magnifications of larger issues in the divorce system, examination of them suggests an agenda for legislative change. This agenda might include:

1. eliminating traditional fault grounds;
2. creating a single statutory unilateral divorce ground on the basis of irreconcilable differences, or some other no-fault terminology, explicitly giving a court the right to deny a divorce in cases of exceptional hardship;
3. authorizing a court to consider egregious marital fault in economic and custody decisions, with a careful definition of terms focusing on serious wrongdoing worthy of moral blame;
4. reviewing the application of maintenance and child support laws and their interaction with public benefits and private insurance programs to ensure that an appropriate balance is struck between family and state responsibility for catastrophic medical care in divorcing families;
5. requiring divorced parents to take their custody and financial obligations to their children and spouses seriously through improved enforcement mechanisms;
6. encouraging out-of-court divorce dispute resolution and shifting resources thereto.

XI. Conclusion

Unless a spouse has engaged in morally blameworthy conduct increasing the risk of HIV infection or transmission to his family, an AIDS-related divorce should be treated as any other, to the maximum extent possible. This premise promotes public health policy, cooperation between spouses and the welfare of the children involved. Courts which have thus far dealt with AIDS-related divorces have demonstrated an admirable capacity to separate AIDS fact from fiction.¹³⁷ They must continue to do so. The legislature should also create mechanisms for the courts and the bar to have access to continuously updated, accurate information about AIDS. It should also carefully review those aspects of divorce law and procedure that encourage general moral condemnation of HIV-infected persons. In most divorce cases, an AIDS-infected person should be viewed as a spouse and parent with an illness, not as a pariah.

137. See cases cited in note 2 *supra*.